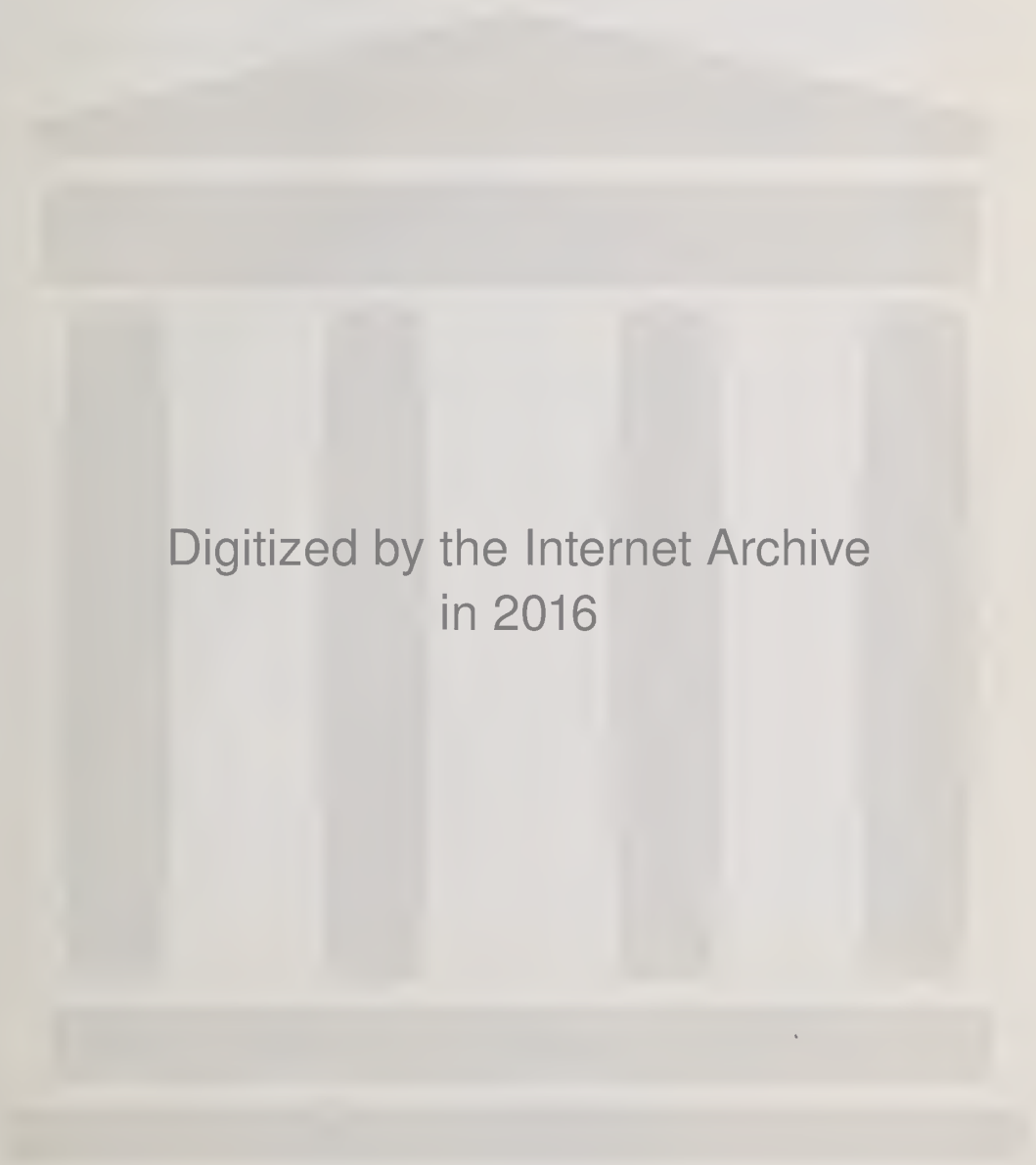
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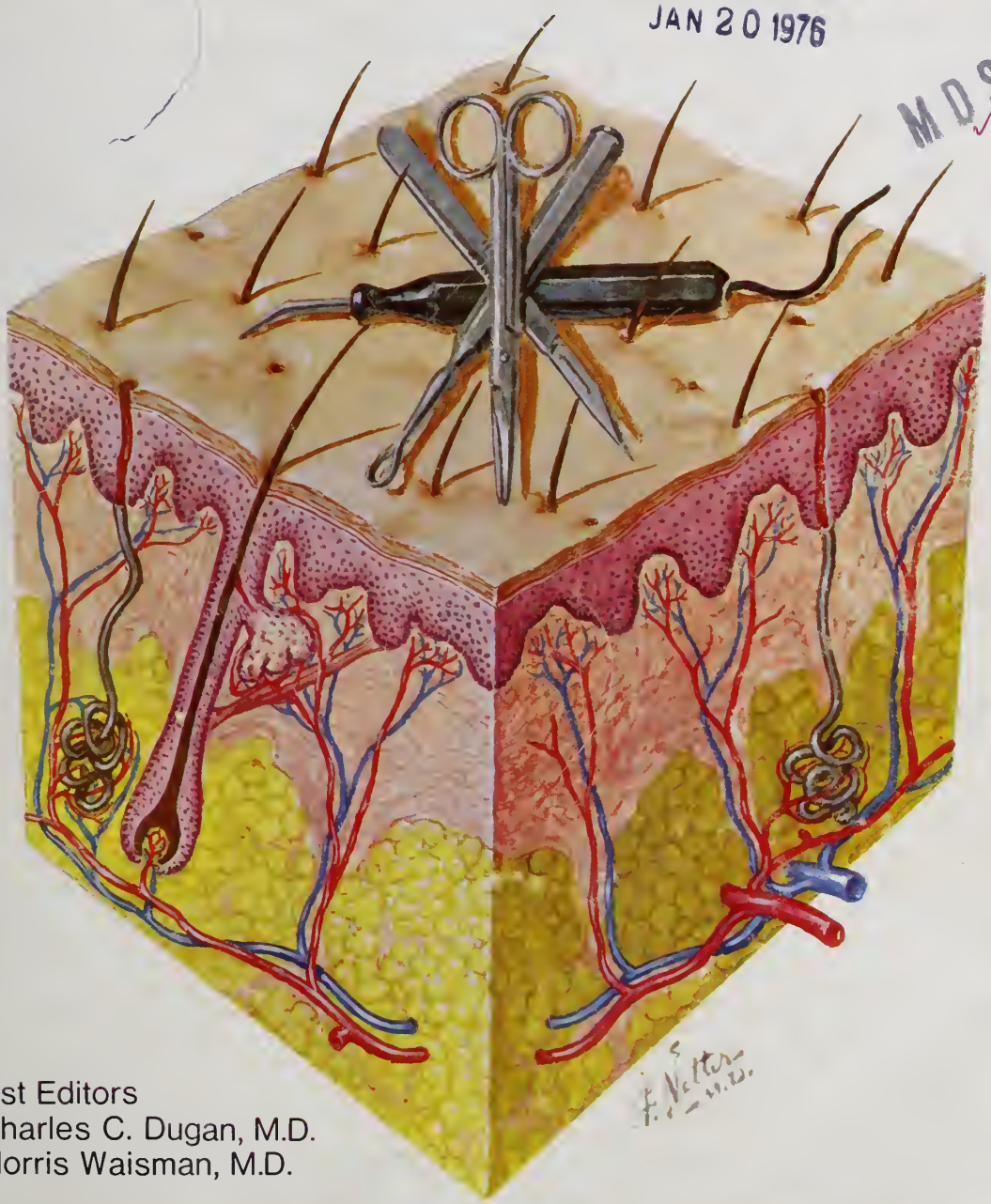
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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC. JANUARY 1976

Special Issue On Dermatology

COLLEGE OF PHYSICIANS
PHILADELPHIA
JAN 20 1976
M.D.S.



Guest Editors
Charles C. Dugan, M.D.
Morris Waisman, M.D.

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓡ IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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Special Dermatology Issue

(SEE CONTENTS OPPOSITE PAGE)

ACKNOWLEDGEMENT: Only through the generous support and financial assistance tendered by the pharmaceutical and surgical suppliers has this expanded special issue of the JFMA on Dermatology been made possible.

We acknowledge their sincere friendship as well as patronage for the Florida Society of Dermatology.

The Florida Society of Dermatology through its membership has prepared the many manuscripts for this issue hoping to provide a short overview of some of the many facets of dermatology as well as portraying some areas in detail to update newer information.

Sections

President's Page
Open Letter to America
VERNON B. ASTLER, M.D. 7

Dean's Page
Consultant for Troubled Times
DONN L. SMITH, M.D. 19

Legislative News
There Are Two Things . . .
JOHN C. KRUSE, M.D. 10

Organization
Position Regarding Medical Professional Liability
VERNON B. ASTLER, M.D. 84

House of Delegates to Convene in Orlando This Month 86

Florida Supreme Court Considers Contingency Fee Modification 87

In Memoriam
Reuben B. Chrisman, M.D.
RICHARD C. DEVER, M.D. 88

Others Are Saying
Rising Militancy
EDWARD W. ST. MARY, M.D. 20

Time is Valuable
LINDSAY R. CURTIS, M.D. 92

Information

Classified Advertising 99

FMA Officers and Council Chairmen 102

Index to Advertisers 102

Meetings 97

January Cover — The cover depicts a cross section of epidermis to highlight this special issue on Dermatology. The Journal of the Florida Medical Association is most pleased to have this cover done by Frank H. Netter, M.D., America's foremost medical illustrator and an honorary member of the Palm Beach County Medical Society. It was done as a courtesy to Dr. and Mrs. Charles C. Dugan, close personal friends of Dr. Netter's.

TABLE OF CONTENTS

SPECIAL DERMATOLOGY ISSUE

Introduction by Special Guest Editor
Charles C. Dugan, M.D. 23

An Approach to Perplexing Dermatologic Disorders
Michael B. Brodin, M.D. 24

The Dermatopathologist
Tobias R. Funt, M.D. 27

A New Look at Gene Determinants and Their Controls
Charles C. Dugan, M.D. 29

The Keratin in Dermatological Diagnoses
Vernon H. Carter, M.D. 32

Malignant Lymphomas, Mycosis Fungoides and Allied Diseases
Allen Baumal, M.D. 35

The Tender, Red Nodules of the Skin Syndrome
Gerald C. Goldman, M.D. 37

Fluorescent Antibody Patterns in Bullous Dermatoses and Lupus Erythematosus
Milton G. Heard, M.D. 42

Skin Problems of Infants
Guinter Kahn, M.D. 45

The Rational Approach to Acne Vulgaris
Stephen H. Mandy, M.D. 48

Alopecia
George Ioannides, M.D. 51

Successful Hair Transplant Surgery—A Composite Evaluation
Leonard A. Lewis, M.D., Sorrel S. Resnik, M.D. and Bernard H. Cohen, M.D. 55

Let There Be Light
Joel M. Wilentz, M.D. and Richard S. Greene, M.D. 57

Pigmentary Changes in Skin Diseases
John H. Hicks, M.D. 60

Problems in Pigmentation
Karl J. Kramer, M.D. and William H. Eaglstein, M.D. 62

Malignant Melanoma or Harmless Mole?
R. Johnson Baker, M.D. 65

Cancer of the Skin
Henry Menn, M.D. 67

Surgical Repair of Operative Defects After Skin Cancer Excision
Terrence A. Cronin, M.D. 71

Current Status of Syphilis and Other Venereal Diseases
Milton S. Ross, M.D. 74

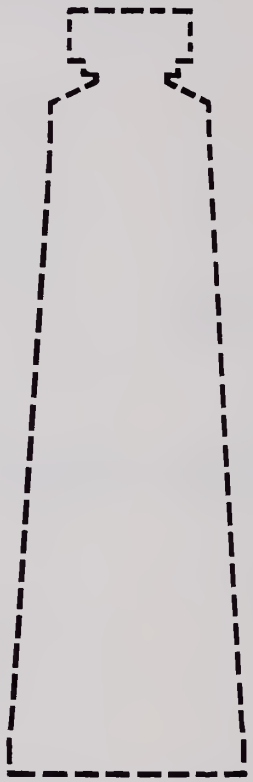
Herpes Progenitalis and Condyloma Acuminata, New Wolves From Old Sheep
Richard C. Childers, M.D. 78

Mighty Mites and Other Bug Bites
J. Kent Bartruff, M.D. 81

289858

OCT 25 1976

On the skin, this famous Infection Fighter is as invisible as the Pathogens it combats



Patients will find this antibacterial product cosmetically acceptable. It vanishes into the skin upon application and leaves no greasy residue. Water-washable. Water-miscible.

Contains three antibiotics that provide broad antibacterial coverage, including virtually all pathogenic bacteria found topically.* These antibiotics are seldom used systemically, so the patient is spared the possibility of sensitization to those antibiotics which might later be required systemically.

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 10,000 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); gramicidin 0.25 mg. Inactive ingredients: liquid petrolatum, white petrolatum, purified water, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, and 0.25% methylparaben as preservative.

*INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For topical administration for the treatment of the listed localized infections or for suppressive therapy in such conditions: • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondary infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions (inflamed or suppurating as a result of bacterial infection).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

HOW SUPPLIED: Tube of 15 g.

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709



President's Page

Open Letter to America

Dear America:

I am one of your native born sons, born of Middle America, and I am proud that I am part of you. You raised me with typical parental beliefs in: the heritage of your forefathers, the Constitution, the Judicial system, freedom and inalienable rights. I have followed your system through competitive public education. I have considered my only rights to be those fundamental, and all others to be blessings or privileges to be earned. I have competed vigorously for academic excellence against heavy odds, and won the privilege of my chosen graduate education. In graduate school I worked and struggled against increasing competition and witnessed a certain rate of attrition among my peers. I studied for years and invested large amounts of money to receive my graduate degree. I then applied and competed for practical training in my profession at below livable wages. Those hardships I endured in pursuit of excellence for my profession, you, my country and myself. I am your doctor!

My brothers (fellow physicians) and I are continuing to meet standards of excellence for licensure, specialty training, mandatory postgraduate education, hospital review and qualification, sponsorship by other physicians, tissue and record review committees, and peer review. These stringent procedures have all been self-established within the medical profession. No other profession has ever exhibited such self-imposed standards of qualification and review toward quality. No other profession has given more time, service and skills to our fellow man. No other profession can point to a record of achievement in areas of disease prevention and ablation, technical advancement, and attention to the human condition.

I have perhaps been too busy to tell you of all medical accomplishments and **your** health story. I have been too involved professionally to have a voice in the media, and yes, I may have succeeded professionally, faltered humanistically, and failed in public relations.

And now my love and concern are with you, America. I hear some of you demanding continued excellence and quality while others (from a more audible podium) demand correction of a "health crisis" and substitution of quantity for quality. I believe in the legislative and judicial process and I trust in the good of our government. Yet, I wonder why congressional committees seeking input on matters of health refuse my testimony or outnumber me 10-1 with garment workers and labor leaders. I wonder how congressmen can even make valid judgments when they fail to appear at their own hearings! And I wonder why our courts continue to confuse less than perfect results with negligence and allow your dollars, America, to pay these bills while many of these same people complain about the rising costs of health care.

I worry, America, when you demand during your hospital stay, electric beds, color TV, gourmet diets, 24 hour service, and then question the costs. I doubt if your Hilton Hotel could serve you better and cheaper. I wonder, America, if you are proud of your doctor and your health care system. Would you overthrow this system and substitute a sweeping national health scheme patterned after those which are presently failing in Europe, and adding billions more in taxes out of your pockets?

These thoughts, America, from the common denominator which is present with a typhoid epidemic, an auto accident, a kidney transplant, or a baby delivered—your doctor.

Vernon B. Astler

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Clinical Considerations: Indications: VALISONE Cream and Ointment are indicated for relief of the inflammatory manifestations of corticosteroid-responsive dermatoses. VALISONE Reduced Strength Cream is indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses. VALISONE Lotion is indicated only in the topical management of seborrheic dermatitis of the scalp. VALISONE Aerosol is indicated, solely, for adjunctive topical management to relieve the inflammatory manifestations of acute contact dermatitis. **Contraindications:** Topical steroids are contraindicated in tuberculosis of the skin and some viral diseases of the skin (varicella and vaccinia). Topical steroids are also contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations. VALISONE Aerosol is contraindicated for use under occlusive dressings. **Warnings:** Keep the spray of VALISONE Aerosol away from eyes and other mucous membranes, avoid inhaling. Avoid freezing of the tissue by not spraying for more than 3 seconds, at a distance not less than 6 inches. Contents are under pressure. Do not puncture. Do not store or use near open flame or heat. Do not expose to temperatures above 120°F. Keep out of reach of children. Never throw container into fire or incinerator. **Precautions:** If irritation or sensitization develops with the use of VALISONE products, treatment should be discontinued and appropriate therapy instituted. In the presence of infection, the use of an appropriate antifungal or antibacterial should be instituted. If favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled. If extensive areas are treated, or if the occlusive technique is used, the possibility exists of sufficient systemic absorption to produce adrenal suppression and systemic corticosteroid effects may occur, suitable precautions should be taken. In a few cases, ulceration has been reported with the use of topical steroids for skin conditions involved with impaired circulation (i.e., stasis dermatitis). **Usage in Women of Childbearing Age:** The use of any drug during pregnancy and the lactation period or in women of childbearing age requires that the potential benefits of the drug be weighed against the possible hazards to the fetus or infant. Topical corticosteroids have not been reported to have an adverse effect on the fetus, but the safety of their use in pregnant patients has not been definitely established. They should not be used extensively or for prolonged periods of time in pregnant patients, unless the condition requiring treatment warrants the risk. VALISONE products are not for ophthalmic use. **Adverse Reactions:** The following adverse reactions have been reported with topical corticosteroids: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, and hypopigmentation. The following may occur more frequently with occlusive dressings than without such therapy: maceration of the skin, secondary infection, atrophy of the skin or subcutaneous tissues, striae, miliaria. **Dosage and Administration:** VALISONE Cream, Ointment, and Reduced Strength Cream are applied as a thin film over the affected skin areas one to three times a day. Clinical studies of VALISONE have indicated that dosage once or twice a day is often feasible and effective. VALISONE Reduced Strength Cream has an aqueous, hydrophilic base that softens and moisturizes the skin. Although occlusive dressings are required infrequently, they may enhance therapeutic efficacy in certain refractory lesions of psoriasis and other dermatoses that are difficult to treat. Apply a few drops of VALISONE Lotion to the affected area of the scalp and massage lightly until it disappears. Apply twice daily, in the morning and at night. Dosage may be increased in stubborn cases, following improvement, apply once daily. Apply VALISONE Aerosol three to four times a day. The container may be held upright or inverted during use. The spray should be directed onto the affected area from a distance of approximately 6 inches and applied for only 3 seconds. Aerosol packaged by Aerosol Techniques, Inc., Armstrong Laboratories Division, West Roxbury, MA 02132.
For more complete details, consult package insert or Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033. MARCH 1974

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For corticosteroid-responsive dermatoses—
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See Clinical Considerations section on opposite page.

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LEGISLATIVE NEWS

"There are Two Things . . ."

In an effort to increase the understanding of Florida physicians of the legislative process, I feel that a brief review of how a bill becomes law would be in order for this month's Legislative news page. Mark Twain is quoted as saying that "There are two things you should never let your children see: How they make sausage and how they make law." There is a great deal of truth as well as humor in this statement, but the various ingredients that go into making a bill a law is the essence of American democracy.

A bill is introduced by any member of either house, and it is then sent to the clerk's office for a bill number, by which it is known on its travels through the legislative process (HB1 or SB1). The Speaker or the President, who also appoints the committees of both houses and their chairman, assigns the bill to one or more committees as he sees fit. Often this assignment will determine the fate of the bill at the outset. Once assigned to a committee, it is set for a hearing date by the chairman. If the chairman sets no date for a hearing, the bill is virtually dead. If a hearing date is held, the bill is discussed publically, perhaps amended, or a committee substitute (CSHB or CSSB) for the bill may be proposed. Such substitutes usually arise from the staff of the committee, which is controlled principally by the chairman. If the bill is passed by the committee (often it has also had to have survived subcommittee hearings, amendments, and votes before it gets to the whole committee), it is sent to the House or Senate floor for action.

In order to reach the floor for debate, however, it must be placed on the calendar by the Committee on Rules and Calendar. The chairman of this committee has great power in setting the order of business before his committee which consists of the chairmen of all the committees and the majority and minority leaders. Bills can be placed on either the Special, Regular, or Consent calendar. Bills on the Consent calendar are noncontroversial and usually passed without debate. If any member objects, it is removed from the Consent calendar. Bills on the Special calendar are taken up as priority items and thus have the best chance of passage. Bills on the Regular calendar are taken up as time permits, and thus may never get acted upon due to lack of time. Once the bill is debated on by the full House or Senate, and passed, it is sent to the opposite house where the entire process repeats itself. If there are differences between the final versions of a bill, one house or the other can acquiesce to the other's version, the differences can be ironed out in a conference committee or the bill may die because of irreconcilable differences. Finally passed in identical form by both houses, the bill is then engrossed and sent to the Governor for his action. The governor can sign the bill, allow it to become law without his signature, or veto it.

This process seems laborious and often is, but it does allow full input by all interested segments of society. Given forceful and able leadership in both houses, it works quite well, especially if the leadership is sympathetic to the aims of a given bill. If they are not, it stands little chance of passage. Given poor leadership, the houses can flounder and much poorly considered legislation can be passed.

Such aims as the FMA has been able to bring into law has resulted in hours of effort spent in educating members of the legislature and especially their leadership in what we are trying to accomplish. Much of this work must be done between sessions in each of our own home towns. If these men and women come to know us as professionals who are putting the interests of our patients first, we will have a greater chance to accomplish our legislative goals when the House and Senate meet next April 1. Know your state Senators and Representatives!

A reminder: Many physicians have not complied with the law passed by the legislature in 1974 which requires that all prescription blanks carry the notation "Substitution allowed (yes or no)" and "Prior approval required (yes or no)." This law was a compromise reached by the FMA and the legislature in response to a demand to reduce prescription costs. Noncompliance is being regarded by legislators as a callous disregard for our patient's pocketbooks and is putting us in a bad light. In order to forestall further restrictive legislation in this area, please buy a rubber stamp for your present supply of prescription pads now and include this box in your next printing.

John C. Kruse, M.D., Chairman
FMA Committee on State Legislation
Jacksonville



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Found useful in the management of vertigo* associated with diseases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



Documented bioavailability... Regimen flexibility

q.i.d. or q 6h immediately after or between meals

E-Mycin®

erythromycin enteric-coated tablets, Upjohn

250 mg

Formulated for quality... Priced for economy.

Upjohn

See facing page for brief summary of prescribing information.

J-4889-9

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astric acidity and to permit efficient absorption when ad-
istered either immediately after meals or when given be-
n meals on an empty stomach.

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otococci): Upper and lower respiratory-tract, skin, and soft-
e infections of mild to moderate severity. Parenteral benza-
e penicillin G is considered by the American Heart Associa-
to be the drug of choice in the treatment and prevention
treptococcal pharyngitis and in long-term prophylaxis of
matic fever. When oral medication is necessary (because
parenteral route is contraindicated) or if there is known
gy to penicillin, the following recommendations made by
American Heart Association apply: 1) Oral penicillin G or V
ere no allergy exists)—This is the drug of choice. Give for
inimum of 10 days; 2) Erythromycin—Give for a minimum
0 days. A few strains of streptococci resistant to erythro-
in have been reported.
a-hemolytic streptococci (viridans group): Short-term pro-
axis against bacterial endocarditis prior to dental or other
rative procedures in patients with a history of rheumatic
r or congenital heart disease who are hypersensitive to
cillin. (Erythromycin is not suitable prior to genitourinary
ery where the organisms likely to lead to bacteremia are
n-negative bacilli or the enterococcus group of streptococci.)
hylococcus aureus: Acute infections of skin and soft tissue
ild to moderate severity. Resistance may develop during
tment.
ococcus pneumoniae: Upper respiratory-tract infections
, otitis media, pharyngitis) and lower respiratory-tract in-
ons (e.g., pneumonia) of mild to moderate degree.
oplasma pneumoniae (Eaton agent, PPLO): In the treatment
rimary atypical pneumonia, when due to this organism.
onema pallidum: Infections due to this organism.
Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.
Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extra-enteric amebiasis requires treatment with other agents.
Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

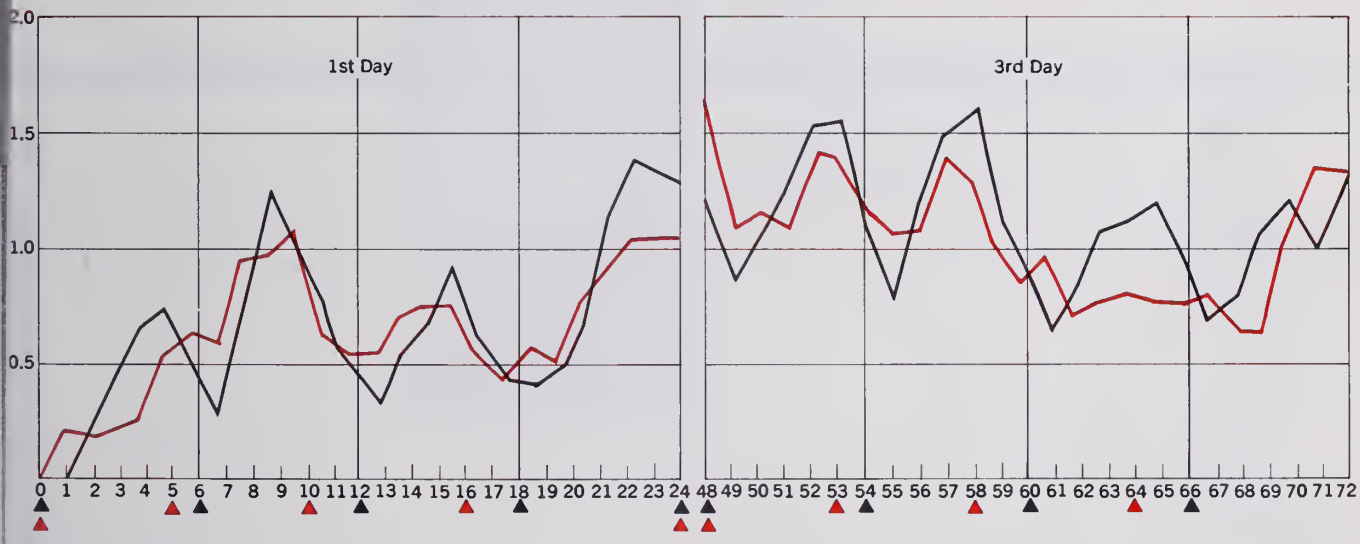
Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of non-susceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

How supplied: 250 mg—in bottles of 100 and in unit-dose packages of 100 enteric-coated tablets. Caution: Federal law prohibits dispensing without prescription.

For additional product information, consult the package insert or see your Upjohn Representative.

monstrated bioequivalence of E-Mycin taken immediately after meals or between meals.



- *Regimen A* (after meals)—One 250 mg E-Mycin® tablet administered q.i.d. immediately after breakfast, lunch, and dinner, and at bedtime with a snack.
- *Regimen B* (between meals)—One 250 mg E-Mycin tablet administered q 6h at least two hours after meals.

E-Mycin Study CS076 on file at The Upjohn Company. The study was performed with twenty-two normal male adult volunteers utilizing a randomized two-way complete crossover design.

statistically significant difference in area under
e curve was observed from 0-24 hours or 48-72
urs at the 95% confidence level ($p>.05$).

e data clearly demonstrate that E-Mycin, when
ministered q.i.d. immediately after meals, pro-
ced average serum levels equivalent to those
tained when the drug was administered q 6h at
ast two hours after meals.

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erythromycin enteric-coated tablets, Upjohn
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MED B 7 5

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?



Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called pati package insert has been around a long time. Many physicians alr use written instruction sheets tc provide patients with informatio about the drugs they are taking. some physicians give verbal inst tions; but in too many instances these are what I call eye-glazing ercises. I have seen patients sit glazed eyes listening to a rapid-f lecture by a hurried physician w has 20 people out in his waiting room. These patients aren't give sufficient understanding and th fore do not follow instructions. S think the idea of an official pack insert for patients is a good one. Perhaps we should really think c this kind of information simply a extension of drug labeling.

The benefits of patient involveme

Many physicians may not r ize how frequently a patient obta his drug information from Aunt Tillie or the next door neighbor. this information is almost alwa bad or irrelevant to the case at h Furthermore, the incentive to gc along with a prescribed program slim if the only reading matter th patient receives, along with his p scription, is a bill.

As an educator I am impres by the principle that the best wa get someone to do something is involve him in the process. So th

I think there are advantage well as some real disadvantages a patient package insert. When y begin to use semi-medical or me cal terms to describe complicati or possible sequelae of disease o treatment, you may frighten the tient—particularly since the mor highly sophisticated patient is nc the one who is going to read the i sert. The patient who will read it the one most susceptible to frigh and confusion by the language.

On the positive side, a pack insert will probably give the patie better insight into why he is bein treated the way he is, and it may give the physician a little bit mor time. But it does not remove fron the physician the need or obligat to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should b warned of the possibility of seriou side reactions—to know what the real dangers are. But it doesn't d bit of good to indicate that a patie on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that frigh engendered by the insert may po sibly outweigh the potential good

ain purpose of drug information the patient is to get his cooperan in following a drug regimen.

eparation and distribution of tient drug information

We would hope to amass inforation from physicians, medical cieties, the pharmaceutical indus- and centers of medical learning. e ultimate responsibility for uni- m labeling must, however, rest th the Food and Drug Administran. There is nothing wrong with s agency saying, "this informan is generally agreed upon and erefore it should be used," as long our process for getting the inforation is sound.

Distribution of the information a problem. In great measure it uld depend on the medication in estion. For example, in the case an injectable long-acting progesone, we would think it mandatory issue two separate leaflets—a ort one for the patient to read be- getting the first shot and a long e to take home in order to make a cision about continuing therapy. this case, the information might put directly on the package and t removable at all. But for a medition like an antihistamine this ormation might be issued sepaely, thus giving the physician the tion of distribution. This could eserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

ly the doctor can remove that fear 20 or 30 minutes of conversation.

I'm not suggesting that we thhold any information from the tient because, first of all, it would totally dishonest and secondly, it uld defeat the very purpose of the sert. I do think that a patient on the th control pill should know about e incidence of phlebothrombosis.

If you're going to tell a patient e incidence of serious adverse retions, then you have to tell him at a concerned medical decision s made to use a particular mediition in his situation after careful nsideration of the incidence of mplications or side effects.

notionally unstable patients pose special problem

There are patients who, beuse of severe emotional problems, uld not handle the information ntained in a patient package inrt. Yet if we are going to have a ckage insert at all, we just can't ve two inserts. I think we might mply have to tell the families of ese patients to remove the insert m the package.

gal implications of the patient ckage insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

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BRIEF SUMMARY
For full prescribing information, see package circular.)
PREMARIN®
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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. **7352**

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PRESCRIBING INFORMATION

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

WORMS BLITZED



A single dose of Antiminth (1 cc. per 10 lbs. of body weight, 1 tsp./50 lbs.—maximum dose, 4 tsp.=20 cc.) offers highly effective control of *both* pinworms and roundworms.

Antiminth has been shown to be extremely well tolerated by children and adults alike in clinical studies.* Pleasantly caramel-flavored, it is non-staining to teeth and oral mucosa on ingestion... doesn't stain stools, linen or clothing.

One prescription can economically treat the entire family.

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NSN 6505-00-148-6967

Pinworms, roundworms controlled with a single, non-staining dose of

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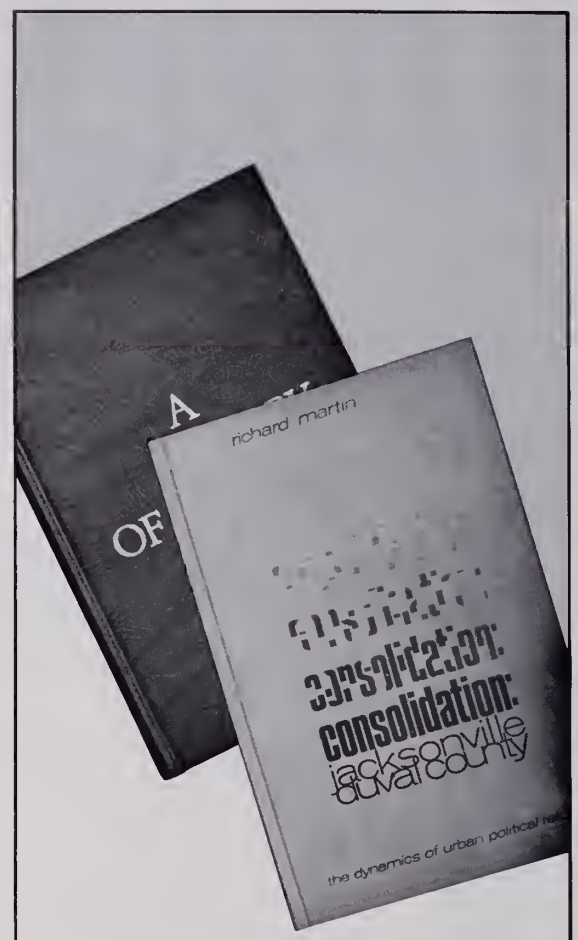
(pyrantel pamoate)

equivalent to 50 mg. pyrantel/ml.

ORAL SUSPENSION

*Data on file at Roerig.

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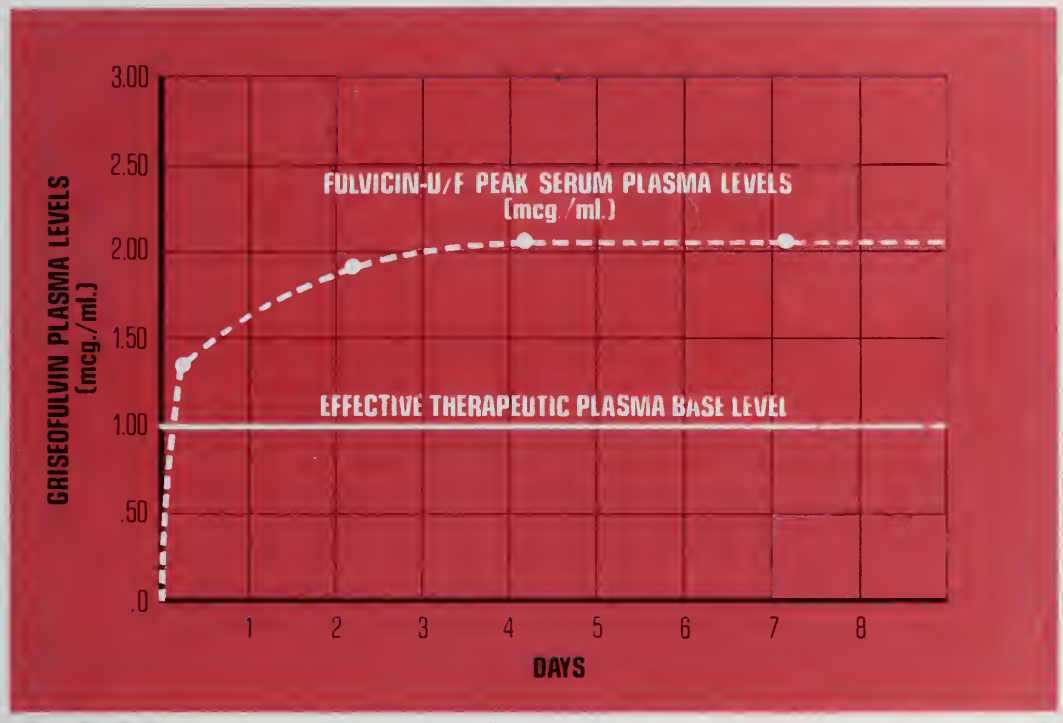
2111 North Liberty Street
Jacksonville, Florida 32206
Telephone 904/354-5555

A Divison of Convention Press, Inc.

FULVICIN-U/F® Tablets brand of griseofulvin (microsize) tablets, U.S.P.
CLINICAL CONSIDERATIONS—
INDICATIONS Griseofulvin is indicated for the treatment of ringworm infections of the skin, hair, and nails, namely: *Tinea corporis*, *Tinea pedis*, *Tinea cruris*, *Tinea barbae*, *Tinea capitis*, *Tinea unguium* (onychomycosis) when caused by one or more of the following genera of fungi: *Trichophyton rubrum*, *Trichophyton tonsurans*, *Trichophyton mentagrophytes*, *Trichophyton interdigitalis*, *Trichophyton verrucosum*, *Trichophyton megnini*, *Trichophyton gallinae*, *Trichophyton crateriform*, *Trichophyton sulphureum*, *Trichophyton schoenleini*, *Microsporum audouini*, *Microsporum canis*, *Microsporum gypseum*, *Epidermophyton floccosum*.
NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.
The use of this drug is not justified in minor or trivial infections which will respond to topical agents alone.
Griseofulvin is not effective in the following: Bacterial infections, Candidiasis (Moniliasis), Histoplasmosis, Actinomycosis, Sporotrichosis, Chromoblastomycosis, Coccidioidomycosis, North American Blastomycosis, Cryptococcosis (Torulosis), *Tinea versicolor*, Nocardiosis.
CONTRAINDICATIONS This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.
WARNINGS **Prophylactic usage:** Safety and efficacy of griseofulvin for prophylaxis of fungal infections have not been established.
Animal toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorogenicity, these studies were not of adequate design to form a basis for conclusions in this regard.
In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin-treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.
Usage in pregnancy: The safety of this drug during pregnancy has not been established.
Animal reproduction studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.
Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.
PRECAUTIONS Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system functions, including renal, hepatic, and hematopoietic, should be done.
Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.
Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.
Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.
Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.
ADVERSE REACTIONS When adverse reactions occur, they are most commonly of the hypersensitivity type, such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate counter-measures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.
Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if graulocytopenia occurs.
When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.
AVAILABLE in 125 mg., 250 mg., and 500 mg. scored tablets.
010 AUGUST 1973
For more complete details, consult package insert or Schering literature available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

SUSTAINED THERAPEUTIC PLASMA LEVELS WITH ONLY ONE TABLET A DAY

Schering



Adapted from Symchowicz, S., and Katchen, B.: J. Pharm. Sci. 57:1383, 1968.

The above graph depicts average peak serum plasma levels of FULVICIN-U/F following once-daily dosage of one FULVICIN-U/F 500 mg. tablet given before breakfast to six normal subjects for a seven-day period.

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brand of

griseofulvin [microsize] tablets, U.S.P.

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SLS-534

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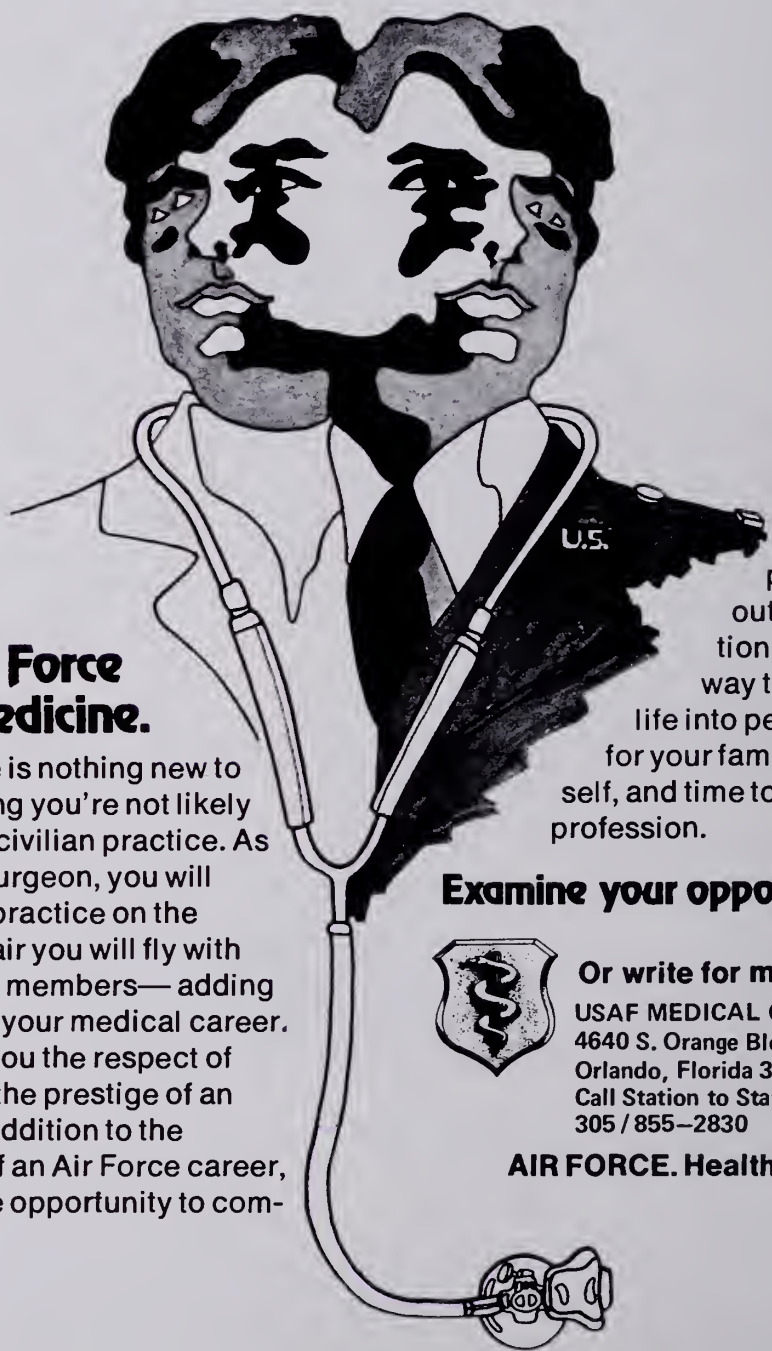
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REFERENCES
1. McColl, J. D., et al.: J. Pharm. & Exp. Therap. 116:343, 1956
2. Quevauviller, Par Andre, et al.: Presse Med. 61:1480-1482, 1953
3. Maney, P. V., et al.: J. Am. Pharm. Assoc. 35:266-272, 1946
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Dean's Page

Consultant for Troubled Times

Donn L. Smith, M.D.

In his valedictory address at the University of Pennsylvania, Osler remarked that, "It has been said that in prosperity our equanimity is chiefly exercised in enabling us to bear with composure the misfortunes of our neighbors." Many of us in medical education have been exercising a high degree of equanimity while observing the trials and tribulations of our practicing colleagues regarding socialization of medicine, politically motivated invasions of the profession, inflationary increases in overhead and a general impairment of the image in which the public holds the physician.

Now it would appear that those of us engaged in and dedicated to medical education will be assured of ample opportunity to display true equanimity in the face of tribulation in our own field of endeavor.

Looming ever larger as a most unpleasant fact is the forced participation in the indenturing of our students, a reduction of significant magnitude in resource for teaching and research and an assault upon our competence related to admissions policies.

These and other serious problems must be faced as the process of medical education operates at a very difficult and complex interface. On one side we are part of the higher education system, which is undergoing major examination by legislatures and the public, with a visible loss of esteem in the eyes of both, and at the other interface our educational product and faculties are part of the medical profession, whose practices are also under severe and probing political and consumer oriented scrutiny.

It is clear that our parents, the University and our children, the practicing physicians are in trouble, and it follows that we as medical educators in the university setting may in no way escape the products of these troubles. In fact, we may well be required to suffer more than one might anticipate because of our occupancy at this difficult interface where we will undoubtedly share the penalties which may be imposed upon either higher education or the practice of medicine.

It will be of great interest and of no small importance to observe the exercise of equanimity by medical educators as we attempt to deal with our own misfortunes which could ultimately cut more deeply into the fabric of medical education than into that of our interface neighbors.

Perhaps Osler's admonition will prove valid; i.e., "One of the first essentials in securing a good natured equanimity is not to expect too much from the people amongst whom you dwell." It is obviously a time for medical education to undertake a realistic and tough-minded evaluation of our own house. Our priorities and mode of operation must be validated and the practical limits of the functions possible to us must be reiterated clearly and with courage. The attempt to force the solution of politically sensitive economic-social problems by manipulation of the educational process can lead only to disaster for medical education as it is now practiced. The price for such disaster must ultimately be paid by the profession and the public as well.

New perspectives and significant changes must be exercised by medical educators if we are to assure the survival of whatever is good and productive in our field of endeavor.

Changes which appear to be inevitable in both medical practice and higher education will have an impact on medical education, and the survival of our Schools of Medicine at any level above that of trade schools will require anticipation, sensitivity and adaptability by the medical faculties across the country.

▸ Dr. Smith, University of South Florida, Tampa 33620.

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

Others Are Saying

Rising Militancy

The rising phenomenona of militancy and revolt in the medical profession is starting to rear its powerful head. Doctors are no longer allowing somnolent canines lie, but are starting to kick back and strike out.

Publicity has been given to the interns' and residents' strike in New York about long hours, fatigue and low wages.

Less publicized are the two suits presented by the AMA. One is in the suit against the Secretary of Health, Education and Welfare blocking implementation of regulations for peer review of the medical necessity for hospital admissions of Medicare and Medicaid patients. The other suit in the court deals with a bill which rolls back our Medicare-Medicaid fees to the 1971 level with a 17% raise for cost of living increase. This seems unconstitutional, in addition to punishing the one who pays the bill—the patient.

Incidentally, the former is the first suit ever initiated by the AMA. Your Editor believes this is a very good sign that the AMA is finally starting to fight back for our benefits. There has been too long a period of time of inaction which has diluted, if not divided our individual county and state medical activities in our behalf.

Moreover, our local organization, the DCMA, is beginning to show its mettle. The Association is "meaner than a junkyard dog" at the fact that there is no representative of the DCMA on the FMA Malpractice Committees. Yet we have more experience in this onerous situation than the rest of the state. Further, Dade represents over one-third of the doctors in the state. This isn't the first time we have been discriminated against by our state organization. Our organization has had resolutions not only to not pay dues to the FMA, but there has been talk of secession from the state organization. Under our charter this is impossible at this point. However, the undertone of militancy is there and for a number of reasons more solidarity in our organization is also present.

We are also becoming more militant in our relations with the press because of their errors and false reporting.

We don't mind paying taxes but we and our patients are inquiring more about where our taxes are spent. The same applies to assessments which were turned down by a large membership turnout at the last DCMA meeting.

We should go further. We should listen to the groups in our own organization. These small groups are making sense. Maybe the minority is really a groundswell from a majority. Time, and our voting, will tell. But we have to vote!!!

We need to be militant about seeking legislation in the malpractice field and in getting teeth into more efficient and effective procedures in policing our own members, who are very small in number but who are hurting us professionally and personally. I refer to the "No Fault Doctors" who work with the unscrupulous lawyers who are also being castigated by their own profession.

There are many needs of reform that the practicing physician is now challenging for a change, and we are being successful.

It appears that we have tried to keep a low profile, subdue our emotions, and acquiesce to the whims of the government and stupid regulations by the bureaucrats for too long a period of time.

No longer!!! We fight—and we fight together. We are now realizing that when change is successful, we can look back and call it growth. We are also realizing that looking back and worrying about the past has no future in it.

Edward W. St. Mary, M.D.
Miami

Reprinted from Miami Medicine, October 1975. Dr. St. Mary is Editor of Miami Medicine.

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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JANUARY, 1976 • VOLUME 63 • NUMBER 1

Special Dermatology Issue

This issue of The Journal was conceived by the members of the Florida Society of Dermatology under the leadership of Dr. Charles C. Dugan, of West Palm Beach.

The Guest Editors of this issue were Dr. Dugan and Dr. Morris Waisman of Tampa. They worked in liaison with Dr. F. Norman Vickers, of Pensacola, who represented the Editors in the final development of this issue. As always, the essential nature of the work of Louise Rader and Ed Hagan of the FMA staff were recognized and appreciated by all involved.

Such an issue by a specialty society is a prestigious undertaking—particularly for Dr. Dugan, since he not only had to organize much of the effort and handle many obstacles but he also had to raise a good share of the funds used to underwrite the extra cost of such a large issue with its aliquot of color photographs.

The Editors of The Journal join me in expressing our thanks to the Florida Society of Dermatology in the conception, development and publication of this issue.—The Editor.

Introduction by Special Guest Editor

Either from lack of exposure or poor early training during the formative years in medical school, most physicians have a limited understanding or appreciation of the specialty field of dermatology. This restricted knowledge of skin mechanisms and its many functions extends also into the realm of interrelationships with the general body functions in both health and disease. Yet the largest single organ of the body is the skin, accounting for one-seventh of the total body weight. It is always the most visual and accessible of all systems in the whole patient.

Because of this general lack of knowledge and understanding, we have prepared a number of short articles covering various aspects of dermatology. Perhaps in this and possibly in future issues, many of those aspects of medicine and surgery of special training and interest to the dermatologist will be introduced. Somewhere this specialty may be surprisingly helpful to you and your patients. We hope that this very superficial brush with the "Scope of Dermatology" may stimulate your concern and curiosity into the mechanisms and magnitude of skin diseases, the interrelationships of skin processes with functions and disease mechanisms of the whole body and the assistance which can be gained from the special knowledge and understanding of the dermatologist in assessing your patients.

This Journal issue is certainly not meant to be comprehensive nor to replace the many excellent texts and journals on dermatology but we would feel that our mission has been accomplished if the reader will better appreciate the skin and its functions in disease as well as in health. Perhaps the reader might even be stimulated to read further into this field or consult with dermatologists not only for obvious skin problems but also for interrelated problems of the whole patient so often clearly understood by the dermatologist which could prove to be very helpful. We would like all physicians to "think skin." It is to this end that we have prepared this special issue on the "Scope of Dermatology."

Charles C. Dugan, M.D.

An Approach to Perplexing Dermatologic Disorders

Michael B. Brodin, M.D.

Dermatologists are confronted daily with two types of clinical problems, those of diagnosis and those of treatment. Of these, the greater problem is diagnosis, and if the clinician is able to name the disease, the problem is nearly resolved. There will be some way for him to excerpt from the body of dermatologic knowledge an adequate form of treatment if one exists.

It must appear to many non-dermatologists that the diagnosis of skin diseases is more intuitive than scientific. This may very well be the case in many of the common dermatoses such as acne vulgaris, atopic dermatitis, psoriasis, warts and basal cell carcinomas. These diagnoses can often be made "with half a glance," as Sir William Osler said (although he made this statement in reference to a case of hypothroidism!) But these diseases do not represent our usual diagnostic problems. Any physician who attempts to diagnose a difficult case accurately must never approach the problem intuitively. It is tempting "to offer a diagnosis as soon as the patient sits down, or even, with a flourish of showmanship, as the patient enters the room."[1] This, however, is only a sign of inexperience. The competent dermatologist practices medicine very carefully and very thoroughly. There is no place in medicine for an instantaneous diagnosis and the resultant haphazard treatment.

For an approach to a difficult diagnostic problem of the skin, I will demonstrate a method of thought that has proven its worth to me. This process should be helpful with the analysis of any dermatological diagnostic problem in order that one can put his clinical knowledge to practical use. The procedure should be applicable to both dermatologists and non-dermatologists.

Diagnostic problems can be classified into two broad categories. The first is the patient who presents with a solitary lesion or a relatively small number of lesions in which the definitive diagnosis is almost always established by pathological study. Examples are cases of nevi and neoplasms. The burden of diagnosis then falls upon the dermatopathologist to support the clinical impression through his interpretation of the skin biopsy specimen. The second is the patient in whom the dermatologist must assume responsibility for the diagnosis, i.e., the group of cutaneous eruptions or "dermatosis". There is no better area in which to undertake a disciplined scientific study of the patient than that in which the diagnosis is not immediately apparent. This method is based upon deductive reasoning. When confronted with a perplexing case, it is time to revert to basics, i.e., basic medicine and basic scientific deductive reasoning.

The scientific method involves (1) a clear statement of the problem, (2) the formulation of a hypothesis to explain the problem and (3) the formulation of experiments designed to prove or disprove the hypothesis. (The scientific method used in research is usually much more complete but is not needed here.)

Here is an elementary example: A male college student presents with an asymptomatic eruption of the trunk and extremities of one week duration. The lesions are erythematous and elevated with a slight degree of scaling. There is pronounced adenopathy, fever and mild pharyngitis. There is no history of a prior genital lesion, of drug intake nor any lesions of the palms or soles.

A physician confronted by such a problem would proceed through the following system:

1. Problem: The patient has a papulosquamous eruption, i.e., the lesions are elevated and scaling.

2. Hypothesis: The eruption is most probably due to invasion of the skin by Treponema pallidum.

3. Experiments: a. Darkfield examination of a skin lesion. b. VDRL c. FTA-ABS.

In this case all tests were positive and the diagnosis of secondary syphilis was made. If they had turned out negative another hypothesis would have been formulated.

The correct diagnosis is found when a set of experiments prove the hypothesis. One merely tests various hypotheses in turn. It sounds simple and it is. The road to follow is the one that is most direct, complexities should be avoided at first. Difficulties will be encountered if this method is not put into effect by accurate and complete formulations at each step. In the foregoing example, for instance, the result would be erroneous. If the patient did not, in fact, have a papulosquamous eruption, or if the experiments (laboratory tests) did not adequately rule out the hypothesis, or if the experiments were not performed properly in the laboratory.

In order to obviate these difficulties, a "checklist" is used. The first step involves an accurate formulation of the problem. The easiest way to do this is to break down the wide variety of cutaneous eruptions into smaller groups (Table 1). The classification which I find most useful follows: 1. macular-pigmentary, 2. maculopapular, 3. papulonodular-cystic, 4. papulosquamous, 5. eczematous-eczematoid, 6. vesiculobullous, 7. pustular, 8. ulcerative-atrophic, 9. poikilodermatous-telangiectatic, and 10. urticarial-erythematous.

Many conditions fall naturally into more than one category and so present in different ways. It is important to remember this in order not to miss an uncommon presentation of a common disease. It is also important to constantly update this list so as not to miss a newly described entity.

After stating the problem in terms of a group of eruptions, it is then necessary to formulate the hypotheses. All possibilities within the groups should be considered in all cases of difficulty, proceeding from the most likely causes first. The probability of any disease within a category being "most likely" will necessarily depend upon the geographical location, age, sex and occupation of the patient among other factors.

The next step, formulation of experiments, again relies upon the checklist system. The first experiments are always clinical. Many disorders within the subgroups are naturally eliminated through the use of history and physical examination especially designed with an eye for detail. There is no substitute for an elaborate investigation into previous eruptions, times of exacerbations, drug intake, etc. Frequently there is need for repetitive questioning into one or more areas coupled with repetitive examinations of the eruption at different times. Aspects of the distribution, configuration and morphology are always necessary to test hypotheses.

Before giving up a case as being thoroughly undiagnosable, the "experiment" checklist should be reviewed in detail. If a specific test is not done, adequate reasons must be given for not doing it. A typical list might be:

1. Scraping, e.g., KOH, Tzanck, Darkfield.
2. Culture, e.g., bacterial, fungal and rarely viral.
3. Biopsy, if necessary more than one; special stains, immunofluorescence.
4. Patch tests, skin tests.
5. Laboratory and x-ray examinations, especially VDRL, CBC and multiphasic screen.
6. Complete history and physical examination.
7. Therapeutic trial.

TABLE I.

The following list includes examples of diseases found in each clinical morphological group. This list presents only a small number of possibilities. The headings may be subdivided and expanded exhaustively to meet personal preference.

1. Macular-pigmentary
 - a. Skin lighter than normal
 - Albinism
 - Oculocutaneous hypopigmentation with leukocyte defects (Chediak-Higashi syndrome)
 - Vitiligo
 - Postinflammatory hypopigmentation
 - b. Skin darker than normal
 - Ephelides (freckles)
 - Lentigenes
 - "Leopard" syndrome
 - Neurofibromatosis
 - Pigmentation polyposis syndrome ("Peutz-Jegher's syndrome)
 - Addison's disease
 - Cushing's syndrome
 - Tattoos
 - Heavy metal deposition
 - Postinflammatory hyperpigmentation
2. Maculopapular
 - Drug eruptions
 - Measles
 - Rubella
 - Roseola
 - Erythema infectiosum
 - Echovirus exanthem
 - Rocky Mountain spotted fever
 - Secondary syphilis
3. Papulonodular-cystic
 - a. Papulonodular
 - Cutaneous metastases
 - Rheumatoid nodules
 - Erythema nodosum
 - Vasculitis
 - Granuloma annulare
 - Sarcoidosis
 - b. Cystic
 - Multiple system cysts with colon polyposis (Gardner's syndrome)
 - Steatocystoma multiplex
 - Basal cell nevus syndrome
 - Multiple epidermal inclusion cysts
4. Papulosquamous
 - Pityriasis rosea
 - Secondary syphilis
 - Psoriasis
 - Parapsoriasis
 - Sarcoidosis
 - Seborrheic dermatitis
 - Tinea corporis
 - Tinea versicolor
 - Lichen planus
 - Pityriasis rubra pilaris
5. Eczematous
 - Atopic dermatitis
 - Lichen simplex chronicus
 - Contact dermatitis
 - Stasis dermatitis
 - Nummular eczema
 - Asteatotic eczema
6. Vesiculobullous
 - Pemphigoid
 - Pemphigus
 - Erythema multiforme
 - Varicella
 - Variola
 - Herpes zoster
 - Herpes simplex
 - Kaposi's vericelliform eruption
 - Contact dermatitis
 - Drug reactions
7. Pustular
 - Acne vulgaris

Acne rosacea
Pyoderma
Pustular psoriasis
Stage of many vesiculobullous disorders (supra)

8. Ulcerative-atrophic
 a. Primarily ulcerative
 Stasis ulcers
 Hypertensive ulcers
 Trophic ulcers
 Decubitus ulcers
 Pyoderma gangrenosum
 b. Primarily atrophic
 Striae
 Panatrophy
 Senile atrophy
 c. Both features
 Radiation dermatitis
 Lupus erythematosus
9. Poikilodermatous-telangiectatic
 a. Poikilodermatous
 Poikiloderma atrophicans vasculare
 Parapsoriasis en plaque
 Hereditofamilial atrophic dermatosis with telangiectasia (Rothmund-Thomson syndrome)
 Dermatomyosltis
 b. Telangiectatic
 Pregnancy
 Hepatic dysfunction
 Benign essential telangiectasia
 Hereditary hemorrhagic telangiectasia (Rendu-Osler-Weber Syndrome)
 Calcinosis Raynaud's phenomenon, sclerodactalia and telangiectasia (CRST Syndrome)
10. Urticarial-erythematous
 Drug eruptions
 Anxiety reactions
 Cold urticaria
 Solar urticaria
 Dermographism
 Insect bites

This list, of course, could be greatly expanded and modified but it is to be expected that further diagnostic aids will become apparent from positive or negative results.

The last point is perhaps the most important. Errors in diagnosis are always made through acts of omission rather than commission. As long as diagnostic tests do no harm, there can be no criticism of the clinician who attempts to eliminate all likely possibilities. All areas must be thoroughly investigated, especially since dermatologists deal with a single organ system. If we ignore the fact that the skin interacts with the body as a whole, we will tend to miss many "perplexing" problems.

In summary, take the following steps in the investigation of a problem patient:

1. Identify the problem as diagnostic in nature. Always remember that patients who do not respond adequately to the drug of choice in a given diagnosis may be receiving treatment for the wrong disease.

2. Classify the eruption into a primary group or, if possible, a subgroup of a group, basing your judgment on the clinical presentation. This should be done carefully; an error in classification will surely result in later errors.

3. Formulate your diagnostic hypothesis. Use the most likely possibilities first.

4. Formulate the experiments that will prove or disprove the diagnosis you have proposed. Refer to the "experiment checklist" if necessary. Obtain the tests that are needed and keep abreast of newer and more accurate laboratory aids.

5. Conduct the tests. If any are confirmatory, the diagnosis is established, if not return to step 3 and try again.

Reference

1. Rook, A., and Wilkinson, D.S.: Textbook of Dermatology, 2nd Ed., 1972, p. 37.

▶ Dr. Brodin, 1510 Barry Street, Suite Q, Clearwater 33516.

Life, like war, is a series of mistakes and he is not the best general who makes the fewest mistakes. Poor mediocrity may secure that, but he is best who wins the most splendid victories by the retrieval of mistakes.

—Robertson

The Dermatopathologist

Tobias R. Funt, M.D.

Rudolph Virchow (1821-1902) is considered the founder of cellular pathology. His description of epitheloid cells, fibroblasts, and other fixed tissue cells prevails today as the foundation of the language of pathology. Dermatopathology, therefore, was originated by Virchow and subsequently developed by numerous microscopists describing disease of the skin. Thus, the heritage of the dermatopathologist developed from such pioneer observers as Ferdinand Hebra, Heinrich Auspitz, James White, Robert Koch, Paul Erlich, Paul Unna, John Bowen, Josef Jadassohn, Bruno Bloch, Samuel Becker, Louis Duhring, Sigmund Pollitzer, J. J. Pringle, Erich Urbach, Howard Hailey, Fred Weidman, Lee McCarthy, Lloyd Ketron, Francis Ellis, and Marcus Caro.

In 1949 Walter Lever published his first text, "Histopathology of the Skin," introducing the era of modern dermatopathology. The 1975 edition is an outstanding text. Other contemporary skin pathologists in recent years have written monumental texts, now classics in American medical literature. These authors include Hamilton Montgomery, Herman Pincus, Amir Mehrigan, Waine Johnson, James Graham, Alvin Zeligson, and Elson Helwig of the Armed Forces Institute of Pathology.

Electron microscopy, histochemistry and immunofluorescence are new tools in the armamentarium of the dermatologist and are useful in diagnosis in areas of skin where the light microscope has its limitations. Because of these tools, pathologists have developed a language in which strange words such as tonofibril, organelle, desmosome, and endoplasmic reticulum describe the ultrastructure of skin and represent a useful means of communication among pathologists.

The rapid growth of dermatology as previously described, resulted in the expansion of training programs for dermatologists and pathologists so that the modern practicing dermatologist is trained in effectively coordinating clinical findings with the histology seen in office practice. The dermatologist is aware that he must examine most tissues, removed as biopsies or totally, even though the lesion may appear benign clinically. It is imperative both medically and legally to know whether a lesion is benign or malignant. Just as the internist occasionally requires consultation in reading an EKG, so does the office dermatologist consult the pathology specialist who may be a general pathologist or a fellow dermatologist with special training, experience and interest in dermatopathology. So that such important consultations may be made available on a high level of competency, the highly prestigious American Board of Pathology and American Board of Dermatology opened their ranks for the first time in the history of medicine to certify qualified pathologists and dermatologists, all of whom must meet rigid requirements to qualify for examination in dermatopathology, bacteriology, histochemistry, electron microscopy, mycology and immunofluorescence. Recognition of the dermatopathologist by the combined American Boards of Pathology and Dermatology represents a giant step forward for the specialties of Dermatology and Pathology. It signifies a bright new era in which the heritage of the pathologist and dermatologist will be additive for the education of the dermatopathologist of the future in the very best interests of the patient and for the practice of medicine.

In reviewing the past 20 years of great medical-dermatological achievement, it is amusing to recall that the first private dermato-pathology laboratory in Florida operated over a kitchen stove in Ft. Lauderdale in November 1954. The medical technician of that laboratory still recalls carrying specimens in a shoebox and stopping at the curb or a traffic light to continue the processing procedure. Today, tissues are processed automatically in autotechnicons, blocked, cut on a microtome, and stained in various ways to provide superbly prepared specimens for examination and diagnosis.

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In the above time frame, the science of skin pathology and important related disciplines developed mainly because of the perseverance of dermatologists greatly interested in pathology and spending valuable hours teaching their resident doctors at our great American medical institutions. And so we recall with pride, contemporary pathologists: John Haserick (Pinehurst), R. K. Winkelmann (Rochester), Louis Winer (L.A.), Victor Torres (Miami), J. Leslie Smith (Houston), Walter Nickel (San Diego), John Knox (Dallas), Robert Freeman (Dallas), Robert Goltz (Minneapolis), George Ioannides (Miami), Herbert Lund (Greensboro), Fred Szymanski (Chicago), George Mikhail (Detroit), Morris Waisman (Tampa), and many others, who made the pathology laboratory an exciting, exhilarating place in which to expand upon the foundations of pathology so meticulously described by Rudolph Virchow about a century ago.

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American Retired Physicians Association Organized in Illinois

The American Retired Physicians Association has been organized and incorporated in Illinois with Mr. Ralph Creer, former American Medical Association staff member, as Executive Director.

Retired and semi-retired physicians and their spouses and widows, age 55 and over, are eligible for membership at $10 per year. According to Mr. Creer, ARPA will concern itself with areas in which retired doctors may continue to be active in community affairs through educational programs in schools, hospitals and other community institutions.

Benefits will include group insurance, tours and purchase plans for major consumer items. A newsletter will soon make its debut.

Founding directors include Huberta M. Livingstone, M.D., former Associate Professor of Surgery at the University of Chicago; Charles V. Heck, M.D., Executive Director of the American Academy of Orthopaedic Surgeons; and Mr. William Smith, Director of the AMA's Department of Membership Legal Affairs.

Information may be obtained by writing to the ARPA, Suite 906, 400 North Michigan Avenue, Chicago, Ill. 60611.

A New Look at Gene Determinants and Their Controls

Charles C. Dugan, M.D.

Abstract: Expanding knowledge of gene loci and their dominant influences is changing medical concepts particularly in predicting disease potentials (genotypes) and assisting in the differential diagnosis or confirmation of a disease state. Advancements in our knowledge of gene association with body functions, immune responses and disease associations have been a spinoff from studies on compatability of HL-A (human lymphocyte antigen) genes for organ transplantations in humans. To avoid rejection of organ transplants as many as forty-four separate gene antigens on the 17th lymphocyte chromosone from the donor and recipient are compared. The more genes that match, the less likely is organ rejection.

In addition to this immune response the presence or absence of disease depends upon specific genetic determinants. Specific genes probably regulate every body function and all its component interreactions. Patients may receive genetic pedigrees from birth.

Expanding knowledge of gene loci and their dominant influences is changing medical concepts particularly in the areas of individual life-time disease potentials and the help which may be provided in confirming diagnoses. Advancements in our knowledge of gene association with body functions, their responses and related disease associations have been a spin-off from studies on HL-A gene compatibility for human organ transplants where as many as 44 antigens are now compared. Genetic determinants may specifically regulate every body function and all component interreactions.

Psoriasis vulgaris, a polygenic multifactorial disease, may eventually be a completely "predictable eruptor." Presently our limited knowledge of HL-A determinants include two which are characteristic of psoriasis, W-13 and W-17. Perhaps HL-A27 is also one of the influencing genes. W-13 is present in only 4% of the general population but in 27% of psoriatics. W-17 has a lower association with psoriasis being present in 23% but is also present in 9% of the general population. When present, however, it is usually a more severe form and is more often associated with a familial history of psoriasis. From the foregoing, we may soon find that specific predictability of psoriatic reactors may be the best approach to an equivocal diagnosis or may be a means of searching out psoriatic genotypes.

Psoriasis is probably mediated by W-13, W-17 and W-27 but possibly also by W-16 and W-18. PGM_3, ME, and IPOB may all relate to psoriasis through the parent immune reactor (Ir) gene. Psoriatic arthropathy is only manifest through W-27 gene. The psoriatic genes W-17 and W-27 were also shown to be prominent in high significance (X^2 to 0.005) in people who have a tendency to develop recurrent infections due to streptococcal organisms. We know that streptococcus infections are a common cause for florid eruptions of guttate psorasis in children and, even in adult psoriasis, streptococcal foci of infections should be sought out. About 85% of psoriatics have some form of streptococcus in their throats, mostly b-hemolytic type A but also found are types B,C,D,E and a-hemolytic streptococcus. The ASO titre in these patients is very low.

In addition to influencing a psoriatic response, you may not appreciate that W-27 is also characteristically associated with several other diseases including rheumatic diseases such as ankylosing spondylitis, Reiter's disease, acute anterior uveitis, psoriatic arthritis with sacroileitis, chronic inflammatory bowel disease, juvenile rheumatoid arthritis, Yersinia enterocolitis with arthritis.

HL-A7 linked to LD-7a is found in 60% to 70% of multiple sclerosis patients but in only 16% of normals; HL-A3 (which may be secondary to HL-A7) and W-8 probably also carry multiple sclerosis and, with less frequency, HL-A2, HL-A12 and W-5. The rapidly progressive severe disease state occurs only in HL-A7. Those patients carrying MCL-7 gene determinants are susceptible to multiple sclerosis but may develop this disease only if they have had an environmental preparatory exposure at an early age to trigger it but not otherwise. This environmental conditioning is usually due to exposure to rubella virus but other viruses such as herpes simplex, varicella, vaccinia, parainfluenza and others may produce the triggering high antibody titres necessary

to form the exogenous, nonspecific, inciting factor in multiple sclerosis. This shares a specific cross-over antibody production to myelin protein. Geographic distributions (more common in Minnesota) often correlate with a high virus attack rate around 15 years of age in the multiple sclerosis patient. This exposure is then followed by a long latency period while developing clonol myelin-specific antibodies.

Disease associations may have a strong gene carrier and a weak gene carrier (one or more) which then are designated as polygenic determinants. For example, multiple sclerosis may have a weak HL-A7 and a strong MCL-7a, 7b, 7c, or 7d which are positioning genes. This is also true in psoriasis with arthritis which usually have W-13 and W-27. But a homozygous gene antigen influencing a disease susceptibility carries a more catastrophic course.

We have learned that W-8 is found in coeliac disease (GSE), myasthenia gravis, dermatitis herpetiformis, Grave's disease and chronic adenohepatitis. In the Caucasian, subacute lupus erythematosus is carried on W-15 but on W-5 in the Negro.

HL-A7 is associated with ragweed RA-5 antigen sensitivity and probably also timothy grass sensitivity. HL-A8 probably controls total body levels of IgE in man where high levels are a recessive trait related to atopic disease. HL-A8 is also associated with rye antigen sensitivity.

W-18 is consistently found in 85% of patients with rheumatoid arthritis but is only present in 15% of nonrheumatoid arthritic reactors. Typing of the HL-A loci is much more accurate for diagnosing rheumatoid arthritis even now than determining the presence of the rheumatoid arthritis factor (RA) and may become as easy a test to perform as the latex test to make this diagnosis. Imagine being able to specifically type each patient and thus be able to predict in **advance** any particular disease and the type of pathology that a specific patient can develop in his lifetime. Preventive measures can then be instituted early in life to avoid a lot of unnecessary problems in that patient's future.

The human leukocyte antigen (HL-A) system in man is correlating well with disease states such as ankylosing spondylitis, Reiter's disease, psoriasis, coeliac disease, chronic hepatitis, myasthenia gravis, multiple sclerosis, Hodgkin's disease, systemic lupus erythematosus and probably most of the fundamental immunological functions as well.

Probably all antigen sensitivities are under some control of the immune response (Ir) region of genes for both cell-mediated immunity and possibly humoral antibodies expressed in "T" and "B" lymphocyte responses. Likewise, these genes control susceptibility or resistance to all disease. A predictable susceptibility of a given patient to allergies or infections can even now be made by HL-A gene studies.

HL-A complex is a **species specific** bank of genetic determinants for humans just as, for instance, H-2 complex is specific for mice, etc. The combinations of these specific determinants vary, but only within a narrow band of 0.8% of the total chromosomal length where HL-A loci are found. These groupings are similar for all humans. Some genes lying outside this HL-A area such as LD and SD genes which are important probably as activators and cytotoxic genes respectively also have similar loci for all species of mammals. Ir genes may control a second set of immune recognition antibodies, possibly on the thymus. In addition, there may be large numbers of accessory gene groupings at other loci which influence disease states but are still unknown.

This new class of Ir genes controlling specific antigen responses has been well identified in laboratory animals. These histocompatibility-linked immune response genes are similar in man and they influence an individual's resistance or susceptibility to neoplastic, autoimmune and infectious diseases with marked specificity of the genetic control. Ir genes control not only antibody levels but also the presence or absence of cell-mediated immunity to specific antigens which as previously stated are expressed primarily in thymus-derived lymphocytes ("T" lymphocytes). These "T" lymphocytes probably recognize antigen carriers attached to hapten antigens to signal "B" lymphocytes which then recognize the hapten antigen itself, thereby releasing antibodies. This statement was proven by creating tetraparent chimeras with mixed populations of responder and nonresponder "T" and "B" lymphocytes. Example: two 8-cell embryos were fused to form a 16-cell blastocoele which was then transplanted into the uterus of a pseudo-pregnant female from a mating with a vasectomized male. Some 30 Ir genes have been precisely mapped near the middle of the H-2 region on the well-studied 17th chromosome of the mouse. Ir genes have also been identified and mapped in guinea pigs and rats. These genes control resistance to virus-induced leukemia, susceptibility to autoimmune thyroiditis and acute lymphocytic choriomeningitis.

Ir genes also carry the alpha-1 antitrypsin factor, one cause of pulmonary emphysema for which many preventive factors such as avoiding environmental precipitators (SO_2, NO_2, ozone, NOX, PAX, CO, ciga-

rette smoke, etc.) can delay an early onset of emphysema.

Reiter's disease which is familiar to all of us is now predictable. Precipitated by a severe epidemic of Shigella dysentery involving 200 passengers and crew aboard a pleasure ship recently, 12 of these patients developed Reiter's disease—all of whom had W-27 loci in their HL-A grouping whereas none of the other patients examined did.

Once the complete genetic label for psoriasis (and many other diseases) is determined, we can use these genetic determiners to label our patients and thus either predict or diagnose psoriasis or the other known controlled diseases even at a very early age. Each patient may get a whole disease classification, like a pedigree, obtained from one chromosome of a single cell genetic labeling. This series of potential diseases may then be carried on the patient as an identification card for quick reference as is now done for the RH factor, blood typing, diabetes, penicillin and other sensitivities.

References

1. McDevitt, H. O.; Bechtol, K. B., and Hammerling, G. J.: Histocompatibility-linked Genetic Control of Specific Immune Responses, Soc. Gen. Physiol. Ser. 29:101-20, 1974.
2. Lonai, P. and McDevitt, H. O.: I-region Genes are Expressed on T and B Lymphocytes. Studies of the Mixed Lymphocyte Reaction (MLR), J. Exp. Med. 140:1317-23, 1974.
3. Mittal, K. K. and Terasaki, P. I.: Serological Cross-Reactivity in the HL-A System, Tissue Antigens 4:146-56, 1974.
4. Ackerman-Schopf, C.; Ackerman, R., and Terasaki, P. I.: Natural and Acquired Epidermal Autoantibodies in Man, J. Immunol. 112:2063-7, 1974.
5. McDevitt, H. O.: Fundamental Characteristics of Histocompatibility-Linked Specific Immune Response (IR) Genes, Transplant. Proc. 5:1799-801, 1973.
6. McDevitt, H. O.: International Symposium on Hodgkin's Disease. Session 1: Epidemiology and Etiology. Pt. 3: Immunology. Invited Discussion. Genetic Factors in Immune Responsiveness, National Cancer Inst. Monogr. 36:135-6, 1973.
7. McDevitt, H. O. and Bodmer, W. F.: HL-A, Immune-Response Genes, and Disease, Lancet 1:1269-75, 1974.
8. McDevitt, H. O.; Oldstone, B. A., and Pincus, T.: Histocompatibility-Linked Genetic Control of Specific Immune Responses to Viral Infection, Transplant. Rev. 19:209-25, 1974.
9. Terasaki, P. I.: HL-A Histocompatibility Determinants, D. M. 1-34, Dec. 1971.
10. Opelz, G. and Terasaki, P. I.: Lymphocyte Antigenicity Loss With Retention of Responsiveness, Science 184:464-6, 1974.

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The Keratin in Dermatological Diagnoses

Vernon H. Carter, M.D.

As physicians we evaluate and react to many conscious and subconscious aspects of the skin when a patient initially confronts us, but few consider the first visual clues as being derived from a layer that is dead. After many years of telling patients how healthy they look, it is startling to realize that we are seeing only nonviable tissue which is visually and texturally altered by the viable portion below or, to a lesser extent, the external environment. However, this thin, translucent layer is unique in that it performs its major function after cell death. Keratin is only a few thin pancake-like cellular layers thick but it becomes the interface between live cells and our total external environment. No other cell can make that claim. Keratin may become diseased by external factors such as physical trauma, radiation, electrical current, and humidity but the greatest interest in this layer comes from its ability to offer clues to previous influences on the epidermis.

An epidermal cell, with its origin in the lower layer of the epidermis, has an average longevity of 30 days. At the instant of origin it is predestined to become a hollow skeleton of keratin and to protect succeeding generations of squamous cells. During its migration "to the top" it is susceptible to many systemic disorders, dermal diseases and factors limited to the epidermal layer. As this cell approaches the keratin layer, it begins to form keratohyalin granules. When these granules are readily visible on hematoxylin and eosin stained slides, this cell becomes a transient member of the granular layer. Afterwards the cell loses its internal structure and becomes a hard shell of keratin and eventually is lost at the outer surface.

During migration a squamous cell is attached to its neighbor at points called desmosomes but at the granular layer another substance arising from ultrastructural bodies (membrane coating granules) becomes apparent and begins the process of cementing keratinocytes to each other. These structures and substances are important in the edematous and bullous diseases of the epidermis and will be treated more elaborately elsewhere (Fig. 1).

Histologic examination of the basic elements of keratinization and their alterations become a useful adjunct to clinical evaluation. They are (1) degree of granularity, (2) extent of keratin formation, (3) type of keratin formed, and (4) lateral involvement. The degree of granularity may be hyper- normo-, or hypogranular. The extent of keratin formation may be hyper-, normo, or hypokeratotic but the type of keratinization is either ortho- or parakeratotic (retention of the nuclei). The final variation is the degree of involvement laterally, and this may be generalized or spotty.

All these processes are evaluated on a relative basis and the region of the body biopsied must be considered in order to establish a "normal." For example, mucous membrane has very thin parakeratotic keratin while at the other extreme the palmar and plantar surfaces have very thick orthokeratotic keratin with an increase in granular layer thickness.

Theoretically, there can be three granular variations, three degrees of keratin thickness and two types of keratinization. It now becomes evident that there are 18 combinations of variables which also may be spotty or generalized giving us 36 potential keratotic differences. Some combinations are not compatible and we do not have a disease fitting those particular histologic findings. It is important when reviewing microscopic sections of skin to establish a subconscious routine of reviewing these variables for any information that can be obtained (Figs. 2-6).

Hyperkeratosis may be due to excessive formation of keratin with increased granular layer as is found in lichen simplex chronicus. If it is due to retention of keratin and the granular layer is normal or decreased, the various ichthyoses are suggested.

Hypokeratosis may be associated with increased granular layer activity as in erythroplasia of Queyrat. There may be loss of keratin from maceration with a normal granular layer as in eczema, or from decreased activity of keratin formation as presents in lichen sclerosus et atrophicus.

Parakeratosis represents rapid keratinization in which the nucleus of the cell is retained. A good

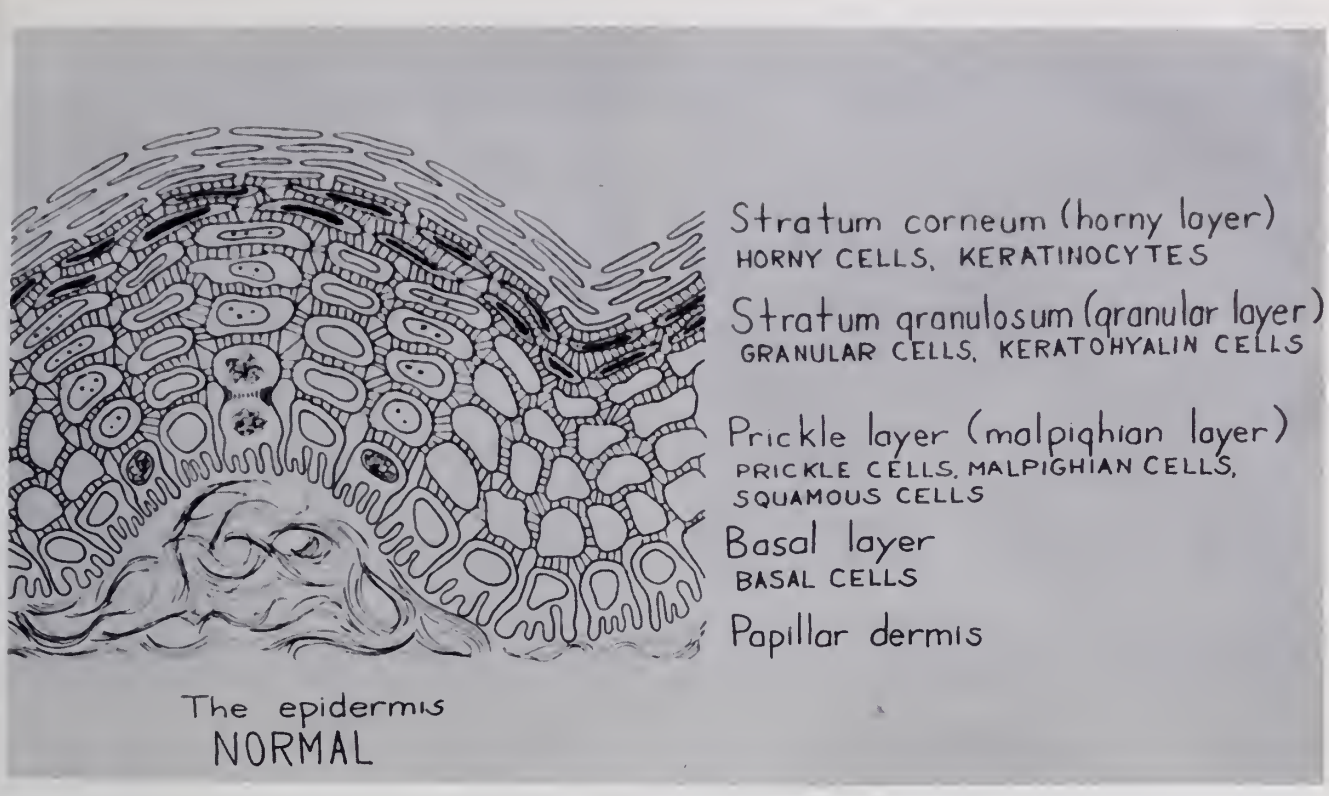


Figure 1



Figure 2



Figure 3

example of this in routine patients is psoriasis. There is a rare disorder of unknown etiology in which keratinization proceeds so rapidly that even the basal layer keratinizes and allows dermis and keratin to be in contact. This is Kyrle's disease which has the descriptive name of hyperkeratosis follicularis et parafollicularis en cutem penetrans and is the ultimate diagnosis of spotty parakeratotic keratinization.

Hypergranulosis is generally seen in diseases which incite hyperkeratosis. A common lesion representative of this formation is the viral wart. Other



Figure 4

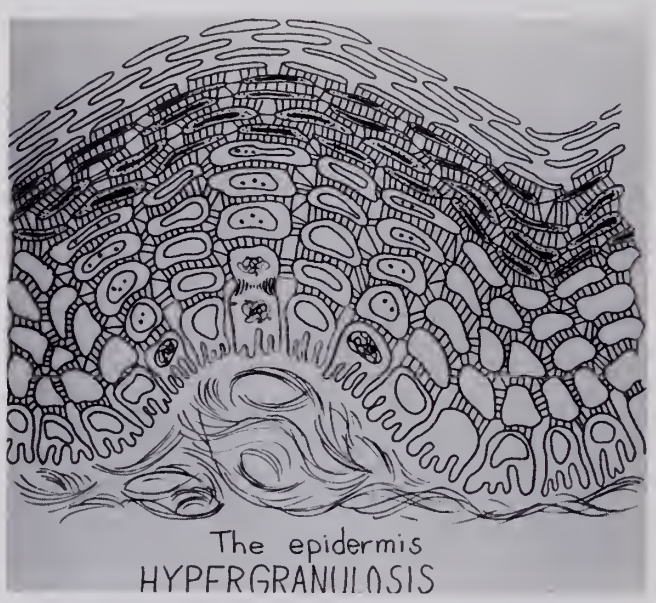


Figure 5

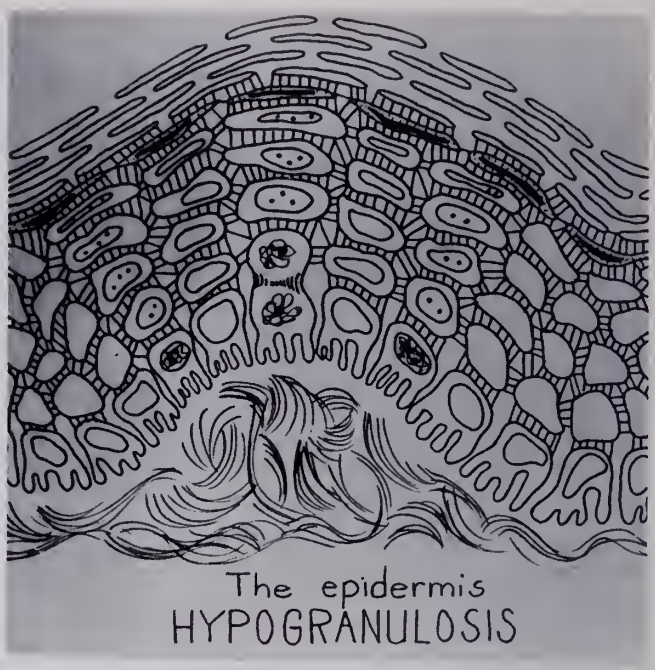


Figure 6

less common diseases are lichen planus, poikiloderma atrophicans vasculare and, to some extent, lupus erythematosus.

Hypogranulosis usually is seen associated with parakeratosis in which there is a rapid turnover rate of the epidermis. This rapid transition from squamous cell to a keratinocyte leaves little time for the orderly process of forming the keratohyalin granules and loss of the nuclei. This combination is well represented in psoriasis and Bowen's disease. There are two disorders which show hypogranulosis without parakeratosis. One is ichthyosis vulgaris which is a superficial disorder and the other is ichthyosis congenita which has its pathogenesis deeper in the epidermis.

Spotty parakeratosis is represented by the mundane pityriasis rosea, seborrheic dermatitis, the garden variety of warts and the more sophisticated diagnosis of parapsoriasis.

The electron microscope is giving us valuable insight into the complex mechanism of keratinization but these investigations are beyond the scope of this brief article. The exact role of the keratohylin granule has not been fully explained but for diagnosis it is helpful always to be aware of its presence. Again, to know the region of the body from where the biopsy was taken and to know the normal histology for that region is vital.

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Malignant Lymphomas, Mycosis Fungoides and Allied Diseases

Allen Baumal, M.D.

Malignant lymphoreticular diseases of the skin are of interest to both the general physician and the dermatologist. Early and accurate detection can lead to specific pathologic diagnoses and often provide effective treatment. Lymphomas notoriously present on the skin in a wide spectrum of clinical features which can mimic numerous other skin disorders.[1,2] The many variations of the clinical features as they relate to the skin will be summarized here. A typical classification of lymphoreticular diseases which affect the skin are presented in Table 1.

One of the more important group of diseases in the classification of lymphomas of the skin is mycosis fungoides. There are three recognized stages: 1. The premycotic stage which can simulate eczema, psoriasis, seborrheic dermatitis, erythema multiforme, pityriasis rubra pilaris or parapsoriasis. In this stage, one usually sees scattered erythematous scaly patches (red or brown) which are often pruritic. 2. The plaque stage which includes irregular shaped, well-demarcated, slightly indurated patches on the skin. 3. The tumor stage presents as various sized and shaped nodules both on infiltrated patches and on normal appearing skin.

Other varieties of mycosis fungoides include generalized erythematous and d'emblee forms. The latter consists of tumors arising on the skin without the appearance of the other stages.

Systemically, mycosis fungoides involves lymph nodes and visceral organs. A small group of these cases develop reticulum cell sarcoma, lymphosarcoma or Hodgkin's disease.

The most effective treatment for all stages of this disease consists of ionization radiation in the form of x-ray, teleroentgentherapy, electron beam, topical nitrogen mustard and cytotoxic chemotherapy.[3]

The prognosis for mycosis fungoides follows a slow relentless course over two to several decades and usually terminates in death.

Another important group of diseases involving the reticulum is Hodgkin's disease. Although primarily a lymphoid tissue disease, there may be specific skin involvement in 5% to 10% of patients. These changes consist of cutaneous nodules and plaques that may undergo ulceration. In most cases, the cutaneous lesions are the result of hematogenous spread or direct invasion associated with widespread lymph node involvement.

Nonspecific involvement of the skin results in pruritus, excoriations, erythema and lichenification. Acquired ichthyosis vulgaris should always suggest the possibility of Hodgkin's disease. Associated herpes zoster is fairly common. The therapy is similar to that outlined for mycosis fungoides.

Sezary's syndrome is a lymphoma characterized by generalized erythroderma, splenomegaly, superficial lymphadenopathy as well as the appearance of a typical monocytic cells in the circulating blood, in the cutaneous infiltrates and in the lymph nodes. Severe pruritus is usually present.

The Sezary cells are indistinguishable from mycosis fungoides cells by light or electron microscopy. The disease is resistant to most forms of therapy and death usually ensues within five years from the date of onset.

Table 1

A Dermopathological Classification of Lymphoreticular Disease of the Skin

I. Lymphomas with a polymorphous infiltrate
 - A. Hodgkins disease
 - B. Mycosis fungoides
 - C. Sezary's syndrome

II. Lymphomas with a monomorphous infiltrate
 - A. Lymphocytic—well differentiated
 - B. Lymphocytic—poorly differentiated (lymphosarcoma)
 - C. Histiocytic—reticular cell sarcoma
 - D. Mixed lymphocytic—histiocytic
 - E. Undifferentiated pleomorphic stem cell
 - F. Undifferentiated Burkitt lymphoma

III. Leukemia cutis

IV. Malignant histiocytosis—histiocytic medullary reticulosis

V. Multiple myeloma

VI. Primary plasmacytoma

VII. Pseudolymphomas
 - A. Spiegler-Fendt sarcoid
 - B. Insect bite reaction
 - C. Drug reaction
 - D. Lymphomatoid papulosis

Monomorphous lymphomas include six described types which have similar clinical features. Specific cutaneous lesions are more common in this disease than in Hodgkin's disease. Specific lesions are usually multiple plum-colored papules or firm subcutaneous nodules. The nonspecific lesions are similar to those of Hodgkin's disease but pruritus is a far less common symptom.

Leukemia cutis is a specific eruption of the skin with nodules which may be diffuse or plaque-like infiltrations, swelling, erythroderma and ulcerations.

The nonspecific leukemids may be urticarial, bullous, erythema multiforme-like, papulonecrotic, eczematous and/or zosteriform. Diffuse erythroderma, hemorrhage and ulcers may occur in this disease. Pruritis is a common finding as is the association of herpes zoster.

Malignant histiocytosis, multiple myeloma and primary plasmocytoma will not be discussed here because of their rarity.

Pseudolymphoma can be defined as "cutaneous lymphoid hyperplasia" which includes a broad variety of benign infiltrates. These may stimulate lymphomas. The most common of these are Spiegler-Fendt sarcoid, insect bite reaction, drug reaction (Dilantin) and lymphomatoid papulosis. These are mentioned because many of these lesions were formerly considered to be malignant but are now known to be benign reactive inflammatory disorders not to be viewed with alarm.

References

1. Lever, W. F.: Histopathology of the Skin, 5th ed., Philadelphia, Lippincott, 1975.
2. Domonkos, A. N.: Andrews' Diseases of the Skin, 6th ed., Philadelphia, W. B. Saunders Co., 1971.

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Social Security Medical Records Under the Federal Privacy Act

Patients are allowed access to medical records maintained on them by federal agencies under the Privacy Act of 1974, which became law on September 27, 1975.

According to Al Ogden, M.D., State Medical Consultant to Florida's Vocational Rehabilitation Program, the new law requires federal agencies to:

—Maintain and use records in a manner that assures that all information is current and accurate and to adopt safeguards against misuse.

—Permit individuals to determine what records pertaining to them the agency collects, maintains, uses or disseminates.

—Permit individuals to prevent records pertaining to them obtained for a particular purpose from being used or made available for another purpose without their consent.

—Permit individuals to gain access to information pertaining to them in federal agency records and to have a copy made of their records, including medical records.

There will be a small number of cases in which direct access to a medical report may have an adverse effect on the individual, according to Dr. Ogden. Medical reports will be screened to identify these cases, and in these cases, reports will be released only to the individual's authorized representative. Procedures apply to both Social Security and supplemental security income disability claims.

The Tender, Red Nodules of the Skin Syndrome

Gerald C. Goldman, M.D.

There exists a polymorphous group of syndromes characterized by inflammatory, noninfectious cutaneous nodules. The lesions are usually tender and red, predominate on the legs, and occasionally become ulcerative. As summarized in Table 1, these syndromes demonstrate histopathologically variable degrees of (1) an inflammatory process in the subcutaneous tissue, panniculitis, and (2) vasculitis in small and/or medium-sized blood vessels.

The appearance of the panniculitis is remarkably constant across the entire spectrum of syndromes and, therefore, usually provides meager assistance in differentiating various clinical types of these nodules. In general, a nonspecific foreign body reaction comprised of histiocytes, giant cells and other inflammatory cells is evoked by injury to subcutaneous fat cells and with subsequent release of metabolic products.

The vascular inflammation either represents a primary event in this reaction chain or develops as a result of a secondary response to inflammation of adjacent fat lobules. Etiologic factors typically remain unknown and are often further obscured by the constancy of the inflammatory reaction pattern seen microscopically in the various syndromes.

Erythema Nodosum (EN)

Best known among the nodules-of-the-legs syndromes is erythema nodosum. The lesions of EN are brightly erythematous and acutely tender nodules on the anterior legs. They usually appear in crops of less than ten. Each lesion varies in size from 1 to 10 cm. in diameter. Fever and arthralgias may accompany their onset. As the lesions evolve, they take on a purplish, contused discoloration and eventually fade without leaving a trace of atrophy, ulceration or depression in the skin.

EN represents the cutaneous expression of an inflammatory reaction to any of a diverse group of hematogenic antigens. In cases of tuberculosis, histoplasmosis, coccidioidomycosis or inflammatory trichophytosis, the onset of an associated EN coincides with development of demonstrable host hypersensitivity, i.e., the skin tests convert to positivity. Indeed, specifically sensitized individuals occasionally develop nodose lesions in response to a tuberculin test, streptococcal antigen, or Frei test antigen.[1] Other associated infectious diseases include viral respiratory disease, influenza, pertussis, lymphogranuloma venereum, psittacosis, leprosy, syphilis, meningococcemia, gonorrhea, and blastomycosis. In children, the syndrome may follow a streptococcal infection at a time when the ASLO titer is predictably undergoing at least a fourfold rise in the serum.[2,3]

Noninfectious diseases which infrequently give rise to EN include sarcoidosis, ulcerative colitis, Crohn's disease, and Behcet's disease. Only rarely does drug hypersensitivity produce lesions of EN, but sulfonamides, halogens, and estrogens[4] have been reported as causes. EN has not been clearly recorded as an associated finding in connective tissue diseases such as rheumatic fever or systemic lupus erythematosus.

The occurrence of EN in some cases can be an indication of prognosis. In tuberculosis, for example, EN is generally an indication of an advanced stage and is often associated with pulmonary effusions or frank dissemination of the disease. On the other hand, EN accompanying coccidioidomycosis is usually interpreted as a sign of increased host resistance, and rapid recovery can be anticipated.

The treatment of EN is directed at the etiologic factors. In the relatively frequent cases of idiopathic EN, management is conservative, with salicylates and bedrest comprising the only therapy indicated. Since the course of EN is self-limited, the use of systemic corticosteroids is almost always unnecessary to control the inflammatory process.

A variant of EN, referred to here as chronic erythema nodosum (also "subacute nodular migratory panniculitis," "erythema nodosum migrans," and "erythema nodosum perstans),"[5,7] deserves special consideration since it appears to be increasingly common in clinical practice. The nodules of chronic EN differ from those of classical, acute EN by virtue of (1) their more protracted course lasting continuously for months or intermittently for even several years, (2) their frequently migratory pattern with lesions tending to coalesce or to migrate centrifugal-

Table 1.—The Pathology of Inflammatory Skin Nodules.

	Panniculitis	Granuloma Formation	Small Vessel Disease	Large Vessel Disease	Comments
Erythema Nodosum	+	±	+	—	Inflammation prominent in subcutaneous septal connective tissue. A vasculitis of small vessels.
Subacute Nodular Migratory Panniculitis	+	±	+	—	A capillaritis has been suggested as initial event in the development of panniculitis.
Weber-Christian Disease	++	±	±	—	A "true" panniculitis. A minimal vasculitis may follow as a secondary process.
Liquefying Panniculitis	++	±	?	—	Pathology is that of W-C disease.
Erythema Induratum	++	++	+	+	Granuloma formation with caseation.
Nodular Vasculitis	+	±	++	+	All degrees of vasculitis seen. Panniculitis less prominent than erythema induratum.
Subcutaneous Nodular Fat Necrosis	++	—	—	—	"Ghost-like" cells and calcific lamellations are diagnostic.
Lipogranulomatosis Subcutanea	++	+	+	±	A focal degeneration of fat cells is perhaps due to a primary vasculitis of subcutaneous vessels.
Thrombophlebitis Migrans	—	—	±	++	Thrombosis and intense inflammation in the walls of larger cutaneous veins. Minimal periphlebitis. Absent panniculitis.
Periarteritis Nodosa	+	—	±	++	Primarily a disease of medium-sized arteries. Panniculitis may result from subcutaneous arteritis.
Allergic Granulomatosis	+	++	++	++	A necrotizing and granulomatous inflammation in the walls of medium and small arteries.
Nodular Dermal Allergid, etc.	+	—	++	—	A "true" vasculitis of small vessels, which may involve deep dermal and subcutaneous capillaries and arterioles.
L. E. Profundus	+	±	±	—	Nonspecific subcutaneous inflammation minor vascular reaction (Lever).
Acid-Fast Panniculitis	++	+	±	—	Nonspecific and granulomatous inflammation.
Post-steroid Panniculitis	++	+	±	—	Perivascular inflammatory reaction of dermis. Needle-shaped clefts in fat cells.
Physicial Panniculitis (cold, oils, etc.)	++	+	—	—	Injected materials may be seen on microscopic exam.

ly, and gradually forming lumpy, deep-seated, smoldering plaques, and (3) their slightly tender sensitivity in contrast to the more painful lesions of acute EN.

The etiology of chronic EN is unknown. The lesions, occurring almost exclusively in young adult females, are sometimes preceded from 1 to 20 days by an upper respiratory infection. No other signs or symptoms accompany the nodules.

Weber-Christian Disease (W-C) and Liquefying Panniculitis

Another less common syndrome associated with tender skin nodules is Weber-Christian disease, or "relapsing, nodular, non-suppurative, febrile panniculitis." It occurs predominantly among young and middle-aged women, but all ages including infants have been affected. There are several distinct features which properly establish W-C disease as a unique clinical entity. The lesions recur in crops at intervals of several weeks or months and are usually accompanied by bouts of mild fever, malaise, and arthralgias. The individual lesion is between several millimeters and 2 cm. in diameter. They are tender, nonmigratory, and may appear anywhere but especially occur on the thighs, trunk, and buttocks. Although the lesions originate deep in the subcutis, they may be adherent to the overlying skin, which is dull red or cyanotic. Unlike erythema nodosum, the nodules of W-C disease involute over a span of several weeks, leaving characteristic saucer-like depressions in the skin from lipoatrophy and fibrosis. Although the etiology of W-C disease is unknown, there is some evidence that an enzyme disorder may be involved. One investigator demonstrated that preceding each attack of nodules, serum lipoprotein lipase levels fell precipitously in a series of eight patients.[8] Intravenous injections of heparin were found to cause both increased output of the enzyme and disappearance of signs of the disease. Iodides even added to table salt may precipitate an acute exacerbation of W-C. The histopathologic picture of W-C disease is a well developed panniculitis. The presence of foam cells, which form from macrophagic phagocytosis of degenerating fat cells, provides useful diagnostic information.

Two variants of W-C disease deserve mention:

Systemic nodular panniculitis. In this disease, the connective tissue, not only of the subcutis but also of viscera, develops some necrosis and degeneration of fat cells. Foam cells may be seen in mesentery, omentum, bone marrow, liver, spleen, lungs and retroperitoneal fat.[9] Clinical manifestations include abdominal pain, hepatomegaly, granulomatous pneumonitis, ileus, retroperitoneal fibrosis, myelproliferative pancytopenia, as well as the subcutaneous nodules seen in more typical W-C disease. The disease may have a fatal outcome due to such serious complications as myocardial infarction and intestinal perforation.

Liquefying panniculitis. This is another form of W-C disease in which an oily, yellow-brown material is discharged from the necrotic surfaces of nodules undergoing liquefaction.[10]

Erythema Induratum (EI) and Nodular Vasculitis

Erythema induratum is another nodular disease in which tender, bluish lesions develop in young and middle-aged women especially on the calves. The nodules typically ulcerate and recur in crops. They are often precipitated by exposure to cold weather. The usually stout legs which are involved show an associated violaceous or perniotic circulation (livedo reticularis) and edema. Early in the course of the disease the lesions may regress during warmer months. Later, indolent ulcers develop ragged, bluish borders. They heal extremely slowly, leaving depressed and hyperpigmented scars.

Much controversy centers around the relationship of EI to tuberculosis. The three main histopathologic features of EI are consistent with a tuberculous etiology: (1) tuberculoid infiltrates with epithelioid and giant cells in the subcutis surrounding blood vessels, (2) caseation necrosis, and (3) severe degenerative and proliferative changes in the walls of arteries and veins. Moreover, tuberculin tests are frequently positive. In some case reports there have been obvious distant foci of active tuberculosis,[11] with clinical improvement of the EI occurring after administration of antituberculosis therapy. On the other hand, isolation of acid-fast bacilli from the nodules has not been clearly demonstrated, nor have guinea pigs injected with tissue from nodules of EI developed tuberculous lesions. Perhaps, EI (like EN) may represent, in some cases, a tuberculid, i.e., an allergic reaction to tuberculous protein circulating as hematogenic antigens.

One variant of EI is nodular vasculitis. This disease is characterized by the development of lesions on the posterior aspects of the legs in women with venous stasis. The nodules resemble EI but they tend to be more tender and acute although ulceration is much less common. The history of tuberculosis is typically lacking, and patients are healthy in all other respects. The course of nodular vasculitis is prolonged, but with alternating periods

of exacerbations and intervals of complete freedom from the effects of the disease. The ultimate prognosis is good, with eventual disappearance of nodules after several years of disease affliction.

There is good evidence for an immunologic abnormality in the pathogenesis of nodular vasculitis. Stringer et al, using immunofluorescent techniques, demonstrated both 7-S gamma globulin and the B_1C-globulin component of the complement system deposited in vascular and perivascular tissue of the lesions.[12] Parish and Rhodes, having similarly found antigen-antibody complexes in skin biopsy specimens, discussed the bacterial nature, both streptococcal and tuberculous, of the antigenic material.[13] Antigen-antibody immune complex vasculitis (Gel and Coambs type II reactions) falls in this category.

Subcutaneous Nodular Fat Necrosis

Subcutaneous nodular fat necrosis is a rare syndrome characterized by recurrent, generalized, tender, red nodules which develop in response to an escape of lipase into the general circulation in patients with either pancreatitis or carcinoma of the pancreas.[14] The cutaneous lesions grossly resemble erythema nodosum in several respects: (1) each crop of nodules fully evolves over several weeks, (2) the lesions develop predominantly on the lower extremities, and (3) they usually heal without noticeable scarring.

Nodular fat necrosis presents some rather distinctive clinical features. Seventy-five per cent of the cases have been in males, usually in their fourth or fifth decade, quite unlike the female preponderance in the syndromes already discussed. Lesions commonly appear on the abdomen, chest, buttocks and arms as well as pretibial skin. In addition, fat necrosis may occur in omentum, mesentery, bone marrow, pleura or pericardium depending on the degree of dissemination of lipase and, perhaps, other pancreatic enzymes. Fever and polyarthritis (sometimes resembling gout) result from periarticular fat necrosis and are the initial symptoms in some cases.[15]

While most patients with nodular fat necrosis give histories of recurrent abdominal pains, absence of pain must be interpreted as carcinoma of the pancreas until proven otherwise. Additional history of either excessive consumption of alcohol or cholecystitis is obtainable in many of the patients whose underlying disease is acute or chronic pancreatitis. Supporting laboratory data for the diagnosis of nodular fat necrosis include elevation of serum amylase, a high ESR, leukocytosis, and sometimes eosinophilia.

One unique feature of nodular fat necrosis is its histopathologic picture which serves readily to distinguish it from other nodular syndromes. All proven cases show abundant "ghost-like" fat cells (thick shadowy walls and absence of nuclei). In later lesions calcific lamellations surround the cells. A secondary inflammatory reaction surrounds the necrotic fat cells but vasculitis and granulomas are conspicuously absent. In those cases which clinically might be mistaken for W-C disease (which also occasionally involves pancreatic inflammation) the pathognomonic ghost cells should be sought for as a means of differentiation.

Several rarer syndromes deserve mention. Lipogranulomatosis subcutanea (Rothman-Makai) is a very uncommon panniculitis seen primarily in children.[16] Lesions are walnut-sized, occur on legs and less frequently on trunk and arms and are typically tender and red. The lesions are more indolent than in W-C disease, and, rather than occurring in crops, they resolve gradually over the course of about a year, during which an occasional fresh nodule may form. Histologically, the lesions resemble W-C disease with necrotic foci in the panniculus surrounded by acute inflammation, subsequent granuloma formation with histiocytic phagocytosis of fat, and ultimately fibrotic replacement of foci of degenerated fat.

Thrombophlebitis migrans (primary recurrent idiopathic thrombophlebitis) presents as successive crops of small, tender, ovoid nodules which persist for months or years and are seen primarily on the legs in male patients. Neither a panniculitis nor a granulomatous disease, thrombophlebitis migrans is the cutaneous manifestation of inflammation and segmental thrombosis of small and medium superficial veins. A diagnostic clue is provided by the linear distribution of the nodules which appear to be migrating along the course of veins. The great significance of this syndrome is its frequent association with underlying carcinoma especially of pancreatic and pulmonary origin. It may also occur as one of the many manifestations of Behcet's syndrome.[17]

Periarteritis nodosa (PAN) in less than 25% of cases may be associated with cutaneous lesions of which the most characteristic are tender, red to violaceous and occasionally ulcerative nodules.[18,19] Although the complete picture would include fever, malaise, hematuria, hypertension, abdominal pain, weight loss, arthralgias and myalgias, neuritis, leukocytosis, and variable eosinophilia, a primarily

cutaneous form of PAN has also been described. Diagnosis depends on evidence of a truly necrotizing panarteritis of the muscular-type arteries in the dermis and subcutis.

Allergic granulomatosis is a rare vasculitis occurring in asthmatics whose manifestations of disease include fever, eosinophilia, skin nodules, and nonthrombocytopenic purpura.[20] In the arteries and extravascular tissue of lungs and skin are granulomatous inflammation and severe necrotizing vasculitis. Also present within the inflammatory zone are fibrinoid degeneration and an exudate of eosinophils surrounded by epithelioid and giant cells.

Isolated cases of systemic lupus erythemathosus with inflammatory nodular panniculitis have been reported.[21] The lesion may be either ulcerative and sclerotic or red and indurated nodules. Other more typical cutaneous findings of LE should be sought to confirm the diagnosis.

Panniculitis may occasionally result from infection with unusual acid-fast bacteria[22] and deep fungal infections. For example, an infection acquired from abrasions in pools and tanks[23] may result in tender, red plaques and nodules, and is due to Mycobacterium marinum. Three weeks after superficial injury, the so-called swimming pool granuloma appears either as an isolated red nodule or as multiple lesions along the course of lymphatics in a sporotrichoid pattern.

An unusual "cold panniculitis" has been produced by exposure of peculiarly predisposed skin to cold temperatures. The resulting indurated plaques and nodules last for two to three weeks. The lesion, which histologically shows changes of panniculitis, is reproducible by application of ice to the skin.[24]

A clinical picture of tender, red nodules may also be factitially produced by intracutaneous injection of various substances. Factitial dermatitis has been induced by injections of paraffins, oils,[25] and silicones,[26] which produce foreign body granuloma.

In conclusion, a working knowledge of the differential diagnosis of syndromes which involve tender red nodules of the skin, either as primary manifestations or as relatively minor features, should facilitate the clinician's search for an underlying disease. If an exhaustive investigation fails to reveal etiologic factors in an otherwise healthy patient with skin nodules, the patient should be managed conservatively until all signs of skin lesions have disappeared.

References

1. Erythema Nodosum, Disease-a-Month, Louis Weinstein, June 1969, Year Book Medical Publishers, Inc., Chicago.
2. "Erythema Nodosum," Lancet 1:256, 1962.
3. Favour, C. B., and Sosman, M. C.: Erythema Nodosum, Arch. Int. Med. 80:435, 1947.
4. Holcomb, F. D.: Erythema Nodosum Associated with Use of Oral Contraceptive, Obst. & Gynec. 25:156, 1965.
5. Fine, R. M., and Meltzer, H. D.: Chronic Erythema Nodosum, Arch. Derm. 100:33, 1969.
6. Perry, H. O., and Winkelmann, R. K.: Subacute Nodular Migratory Panniculitis, Arch. Derm. 89:170, 1964.
7. Hellerstrom, S.: Erythema Nodosum, Acta Dermato-Venerol, 46: 468, 1966.
8. Medical World News, p. 59, March 22, 1968.
9. Arnold, et al.: Weber-Christian Disease with Visceral Involvement, Canad. Med. Assoc. J. 89:1138, 1963.
10. Hoyos, et al.: Liquefying Nodular Panniculitis, Arch. Derm. 94:436, 1966.
11. Montgomery, H. et al.: Nodular Vascular Disease of the Legs, JAMA 128:335, 1945.
12. Stringer, S. G. et al.: Nodular Vasculitis, J. Invest. Derm. 46:1-5, 1966.
13. Parish, W. E., and Rhodes, E. L.: Bacterial Antigens and Aggegated Gamma-globulin in Lesions of Nodular Vasculitis, Brit. J. Derm. 79:131, 1967.
14. Case Records of MGH, Case 28-1964, New England J. Med. 270:1248, 1964.
15. Mullen, G. T. et al.: Arthritis and Skin Lesions Resembling Erythema Nodosum in Pancreatic Disease, Ann. Int. Med. 68:75, 1968.
16. Laymon, C. W., and Peterson, W. C.: Lipogranulomatosis Subcutanea (Rothman-Makai), Arch. Derm. 90:288, 1964.
17. Gillam, P. M. S.: A Case of Thrombophlebitis Migrans, Brit. Med. J. 1:721, 1961.
18. Fisher, I., and Orkin, J.: Cutaneous Form of Periarteritis Nodosa —An Entity, Arch. Derm, 89:180, 1964.
19. Ruiter, M.: The So-called Cutaneous Type of Periarteritis Nodosa, Brit. J. Derm. 70:102, 1958.
20. Variale, P. et al.: Allergic Granulomatosis, Arch. Int. Med. 113:235, 1964.
21. Winkelmann, R. K.: Panniculitis and Systemic Lupus Erythematosis, JAMA 211:472, 1970.
22. Cantwell, A. et al.: Unusual Acid-fast Bacteria in Panniculitis, Arch. Derm. 94:161, 1966.
23. Adams, R. M. et al.: Tropical Fish Aquariums, JAMA 211:475, 1970.
24. Solomon, R., and Beerman, H.: Cold Panniculitis, Arch. Derm. 88:897-900, 1963.
25. Crosbie, R., and Kaufman, H.: Self-Inflicted Olegranuloma of Breast, Brit. Med. J. 3:840, 1967.
26. Winer, L. et al.: Tissue Reactions to Injected Silicone Liquids, Arch. Derm. 90:588-593, 1964.

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Trifles?

Sometimes when I consider what tremendous consequences come from little things—a chance word, a tap on the shoulder, or a coin dropped on a newsstand—I am tempted to think. . . .there are no little things.

—Bruce Barton

Fluorescent Antibody Patterns in Bullous Dermatoses and Lupus Erythematosus

Milton G. Heard, M.D.

Fluorescent antibody tagging of abnormal immunoglobulin deposits in the skin of persons with lupus erythematosus and certain chronic bullous eruptions has become a useful and widely employed diagnostic aid in the practice of dermatology. Since Burnham[1] first described the use of this technique in lupus erythematosus in 1963 other contributors[2-5] have widened the field of immunofluorescence in dermatology by describing specific fluorescent patterns in pemphigus,[6-9] pemphigoid [10,11] and dermatitis herpertiformis.[12,13] Characteristic microscopic fluorescent patterns occur when fluorescein-labeled antihuman immunoglobulins are incubated with fresh frozen sections of biopsy material from affected patients. This fluorescent antihuman globulin combines with and thereby demonstrates the abnormal immunoglobulin deposits in the skin. Under the microscope these deposits appear as characteristic patterns. This is known as the direct immunofluorescent technique whereby fluorescein-tagged antihuman immunoglobulin is incubated directly with biopsy sections and is demonstrable in all of the previously listed skin diseases.

Patients with pemphigus and pemphigoid also have circulating antiepithelial antibodies composed predominately of IgG in their sera which can be demonstrated by the indirect immunofluorescent technique. In this procedure the patient's serum is first incubated with sections of normal skin, monkey esophagus or other suitable epithelia to allow the abnormal antiepithelial antibody in the serum to become deposited at its characteristic site on the substrate epithelium prior to incubating it with fluorescein-tagged antihuman immunoglobulin.

In lupus erythematosus the characteristic immunofluorescent pattern occurs at the dermal-epidermal junction. The pattern consists of a continuous fluorescent band occupying the basement membrane zone. Several pattern variations have been described according to the morphology and age of the lesion biopsied and are present in about 90% of cases of both systemic lupus erythematosus and discoid lupus erythematosus when the biopsy is taken from a skin lesion.[11,15,17] Variations in this LE pattern depend upon the age and morphology of the clinical lesion. The older, well established lesions with atrophy and hyperkeratosis characteristically demonstrate a solid homogenous brightly fluorescent band as illustrated in Figure 1. A granular or stippled fluorescent band is found in biopsy specimens taken from the uninvolved or normal appearing skin in 30 to 50% of cases of active systemic lupus erythematosus but not in discoid lupus erythematosus. It has been frequently noted that the presence of a positive fluorescent "band" test in cases of systemic lupus erythematosus especially in uninvolved skin is directly related to the activity of the disease and correlates with increased renal and other internal organ involvement and decreased serum complement levels.

Pemphigus vulgaris is a chronic bullous eruption characterized by extensive oral and cutaneous bullae and painful erosions. Frequently insidious in onset, the disease progressively becomes generalized and



Fig. 1.—Lupus Erythematosus. Homogenous fluorescent pattern at dermal-epidermal junction. Direct IF on patient's lesion.

debilitating and if untreated with appropriate systemic corticosteroid therapy often progresses to a fatal outcome. Pemphigus erythematosus, pemphigus foliaceous and pemphigus vegetans are considered variants with perhaps a milder course, but in all cases early diagnosis and treatment are vital. Both epidermal deposits and circulating antiepithelial antibodies are present in the skin and serum of patients with all varieties of pemphigus as demonstrated by the direct and indirect immunofluorescent techniques respectively, using fluorescein labeled antihuman IgG.[6] The fluorescent pattern formed in this case is an intraepidermal, intercellular pattern fluorescing the intercellular spaces within the epidermis and/or substrate epithelia (Fig. 2). In addition to its diagnostic value the indirect immunofluorescent technique can also be useful in monitoring the progress of the patient under treatment by serially titering the patient's serum. The highest dilution which will cause the substrate epithelia to develop a typical fluorescent pattern is the end point and rises and falls in direct relationship to disease activity.

Pemphigoid is characterized by a general bullous eruption which although unrelated to the other bullous dermatoses frequently poses a difficult differential diagnostic problem especially early in the course of the disease. At the outset, the lesions may be confused with bullous erythema multiforme, pemphigus or bullous dermatitis herpetiformis. Though the course of pemphigoid is usually considerably less severe and protracted than pemphigus and is often self-limited, it generally affects the elderly and debilitated, thus making it most desirable to obtain an early diagnosis and begin appropriate corticosteroid therapy.

In most patients with pemphigoid, a characteristic fluorescent antibody pattern is readily demonstrated by immunofluorescent testing with antihuman IgG (Fig. 3).[10] This characteristic pattern is located at the basement membrane zone as seen in lupus erythematosus but, unlike the pattern seen in lupus erythematosus, it is composed of a continuous "tubular" structure and is demonstrable by both direct and indirect techniques. Unlike pemphigus, serial titering of patients' serum followed by indirect immunofluorescence has not correlated well enough with the clinical course to be useful as a parameter for monitoring steroid dosage.

Dermatitis herpetiformis is characterized by a chronic but not usually debilitating course. It may present and continue as a pruritic papular eruption with few if any vesicles and bullae or it may appear as a severe bullous eruption which may be confused clinically with pemphigoid, bullous erythema multiforme or occasionally pemphigus. A characteristic fluorescent antibody pattern demonstrated by the direct immunofluorescent technique using antihuman IgA has been found to be present in biopsy material taken from the skin immediately adjacent to a

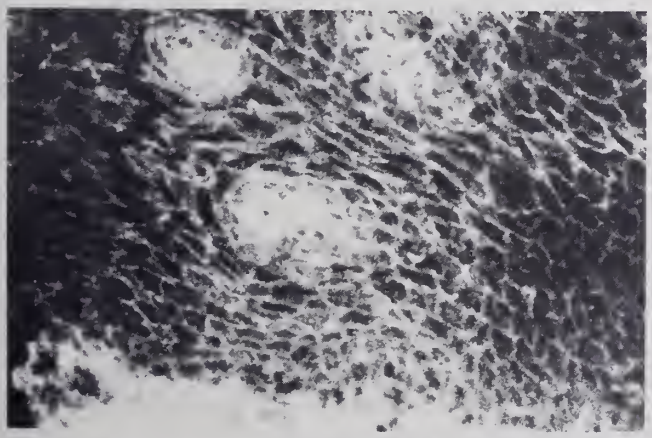


Fig. 2.—Pemphigus. Intevellular fluorescent pattern. Indirect IF on monkey esophagus substrate.

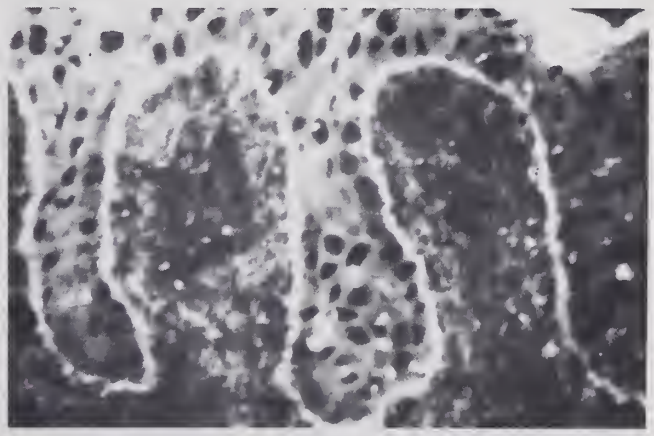


Fig. 3.—Pemphigoid. Continuous "tubular" pattern. Indirect IF on human skin substrate.

lesion (Fig. 4).[12] This pattern, like that of lupus erythematosus and pemphigoid, is located at the dermal-epidermal junction. It is, however, characteristic in that it is a discontinuous speckled pattern concentrated at the tips of the dermal papillae. IgA is predominately found deposited in dermatitis herpetiformis unlike the IgG deposits of lupus erythematosus, pemphigus and pemphogoid.

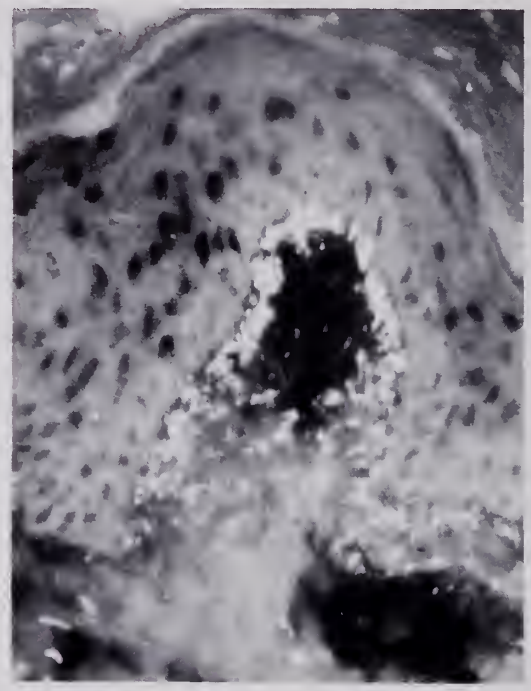


Fig. 4—Dermatitis Herpetiformis. Discontinuous fluorescent pattern at dermal papillary apex. Direct IF.

Identification of the constituents present in the in vivo bound immunoglobulin deposits responsible for fluorescent antibody patterns has been the subject of a number of investigations.. The deposits at the basement membrane zone in lupus erythematosus have been adequately shown to contain IgG and complement consistently and IgA and IgM usually.[1,3,4,5,12] IgG is the most common component and IgA is the least common. In pemphigus[8,17] and pemphigoid[10,17,18] IgG and usually complement are present in the intercellular spaces and at the dermal-epidermal junction respectively while IgM and IgA are not regularly present. In dermatitis herpetiformis the predominant gamma globul in deposit is IgA and secondarily IgG and complement.[12,13,19] These findings well document the role of IgG in the formation of cutaneous gamma globul in deposits in lupus erythematosus, pemphigus and pemphigoid and of IgA in dermatitis herpetiformis, lending significant but inconclusive support to the autoimmune pathogenesis of these diseases.

References

1. Burnham, R. K.; Neblett, T. R., and Find, G.: Application of Immunofluorescent Technique To Investigation of Lupus Erythematosus and Various Dermatoses, J. Invest. Derm. 41:451-456, 1963.
2. Cormane, R. H.: "Bound" Globulin in Skin of Patients with Chronic Discoid Lupus Erythematosus and Systemic Lupus Erythematosus, Lancet 1:534-535, 1964.
3. Pohle, E. L., and Taffanelli, D.: Study of Cutaneous Lupus Erythematosus by Immunohistochemical Methods, Arch. Derm. 97:520-526, 1968.
4. Tan, E. M., and Kunkle, H. G.: Immunofluorescent Study of Skin Lesions in Systemic Lupus Erythematosus, Arthritis Rheum. 9:37-46, 1966.
5. Ten-Have-Ophrock, A. A. W.: Demonstration of Immunoglobulins and Complement in Skin of Patients with Lupus Erythematosus, Acta Dermatovener 46:68-71, 1966.
6. Beutner, E. H., and Jordan, R. E.: Demonstration of Skin Antibodies in Sera of Pemphigus by Indirect Immunofluorescent Staining, Proc. Exp. Biol. Med. 117:505-510, 1964.
7. Beutner, E. H.; Lever, W. H., and Witebsky, E., et al: Autoantibodies in Pemphigus Vulgaris; Response to Intercellular Substance of Epidermis, JAMA 192:682-688, 1965.
8. Cormane, R. H., and Chorzelski, T. P.: "Bound" Complement in Epidermis of Patients with Pemphigus Vulgaris, Dermatologica 134:463, 1967.
9. Chorzelski, T. P.; vonWelss, J., and Lever, W. F.: Clinical Significance of Autoantibodies in Pemphigus, Arch. Derm. 93:570, 1966.
10. Jordan, R. E.; Beutner, E. H.; Witebsky, E.; Blumenthal, G.; Hale, W. I., and Lever W. F.: Basement Zone Antibodies in Bullous Pemphigoid, JAMA 200:751, 1967.
11. Chorzelski, T. P., and Cormane, R. H.: Presence of Complement Bound in vivo in Skin of Patients with Pemphigoid, Dermatologica 137:134, 1968.
12. Chorzelski, T. P.; Beutner, E. H., and Jablonska, S., et al: Immunofluorescent Studies in Diagnosis of Dermatitis Herpetiformis and Its Differentiation from Bullous Pemphigoid, J. Invest. Derm. 56:373, 1971.
13. Meer, J. B. van der: Granular Deposits of Immunoglobulins in Skin of Patients with Dermatitis Herpetiformis: Immunofluorescent Study, Brit. J. Derm. 81:493, 1969.
14. Burnham, R. K., and Fine, G.: Immunofluorescent "Band" Test for Lupus Erythematosus, Arch. Derm. 103:24-32, 1971.
15. Burnham, R. K., and Fine, G.: Immunofluorescent "Band" Test for Lupus Erythematosus, Arch. Derm. 99:413-420, 1969.
16. Kay, D. M., and Tuffanelli, D. L.: Immunofluorescent Techniques in Clinical Diagnosis of Cutaneous Disease, Ann. Int. Med. 71:753-761, 1969.
17. Beutner, E. H.; Jordan, R. E., and Corzelski, T. P.: Immunopathology of Pemphigus and Bullous Pemphigoid, J. Investigative Derm. 51:63-79, 1968.
18. Cormane, R. H., and Szabo, E.: Immunohistopathology of Skin in Pemphigoid, Brit. J. Derm. 83:435-445, 1970.
19. Cormane, R. H.; Szabo, E., and Hauge, I. S.: Immunofluorescence of Skin: Interpretation of Staining of Blood Vessels and Connective Tissue Aided by New Techniques, Brit. J. Derm. 82:26-41, 1969.

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Skin Problems of Infants

Guinter Kahn, M.D.

The infant's skin is thinner than the adult's, less hairy, has less sweat and sebaceous gland secretions, weaker intercellular attachments and blisters more easily. Some of the problems that may be encountered are transient and disappear without treatment. Others require careful examination, laboratory investigation, and exacting therapy.

Toxic Erythema

Toxic erythema—benign, self-limiting—most often begins on the infant's second day, lasts from hours to days, and is characterized by blotchy erythema superimposed with pale, tiny papules and pustules. Commonly present on the trunk, it may occur elsewhere except the palms and soles. A histopathological section or Wright or Giemsa stained smear demonstrates an infiltrate of eosinophils. The cause of the condition is unknown. Toxic erythema is a misnomer; it is not secondary to a toxic disease and has no systemic manifestations.

Milia

Milia occurs in about 40% of newborns. Tiny epidermal inclusion cysts are found most commonly on the face and disappear in about a week without treatment. Epstein's pearls are the intraoral counterpart and occur in about 85% of newborn infants.

Miliaria Crystallina

Miliaria crystallina commonly occurs on the forehead, upper trunk and volar arm surfaces of infants a day or two after birth who are maintained in a warm, humid environment. It represents sweat retained just beneath the stratus corneum. If heat and occlusion continue, a deeper miliaria (rubra) may form which manifests as pruritic red papules.

Acne Neonatorum

Acne neonatorum may occur as papules and pustules on the face in response to maternal hormones. Neonatal acne may be confused with the tiny papules of sebaceous hypertrophy found on the nose one week after delivery and is also secondary to maternal hormones. Non-oily cleansing may be the only therapy necessary. When the eruption persists, a virilizing syndrome should be ruled out.

Nontransient Conditions

Flat Hemangiomas or Port-Wine Stains

Flat hemangiomas or port-wine stains usually are present at birth. About 20% of strawberry or capillary hemangiomas are noted at birth, but there may be premonitory signs for the remainder.[1] They include telangiectatic lesions surrounded by a pale halo, red puncta over dilated blood vessels, pale patches which later become telangiectatic, bruise-like lesions which become nodular, and simple uniform erythema which subsequently become nodular. The physician should be assured that these sentinels are not present before informing the parents that their child is or will be blemish-free, especially since surface elevation of the lesion may occur about three weeks after the premonitory signs.

Most hemangiomas are treated by measuring, photographing and watching. Regression usually begins after the child's first year. Systemic or intralesional corticosteroids are used only for the treatment of severe hemangiomas or those encroaching on vital structures. Compared with strawberry hemangioma, the prognosis for lymphangioma is poor. A few case reports indicate that corticosteroids are useful in its treatment which might provide an alternate approach to therapy since surgery often is associated with recurrence and disfiguring scars.[2]

Klippel-Trenaunay-Parkes-Weber Syndrome

Until now there has been no established, regularly beneficial treatment for this syndrome in which unilateral, flat vascular nevi, present at birth, cause overgrowth of bony and soft tissue structure of the involved limb. Dr. Davis of Children's Hospital in Denver reports successful use of x-ray therapy.[3]

Congenital Syphilis

Congenital syphilis is occurring more frequently than in the past 20 years.[4] The most common signs are noted in the long bones as inflammation and in

the liver or spleen as enlargement. Mucous membrane signs of rhinorrhea (snuffles) may be present at birth but blisters of the palms and soles and maculopapular rashes around the orifices often do not occur until two or more weeks. Not all luetic mothers give birth to luetic infants.

Denuding Bullous Diseases

Three denuding bullous diseases appear alike at birth: (1) epidermolytic hyperkeratosis, dominantly inherited, called congenital bullous ichthyosiform erythroderma; (2) dystrophic epidermolysis bullosa, recessively inherited, called dermolytic bullous disease, and (3) Ritter's toxic epidermal necrolysis appearing only hours after birth caused by a toxin liberated by Staphylococcus aureus phage type 71. It is treated with semisynthetic penicillin-like drugs. The histopathological picture shows epidermolytic hyperkeratosis characterized by vacuolation of the granular layer, epidermolysis bullosa dystrophica as separation of the epidermis from the dermis, and toxic epidermal necrolysis characteristically as upper epidermal necrosis. A biopsy is mandatory to confirm the diagnosis.

Cutis Aplasia Congenita

Cutis aplasia congenita is localized denudation of the skin occurring primarily on the posterior midline of the newborn scalp. Most defects are oval or round, less than 2 cm. in diameter, become covered by a cigarette paper-like scar in the early weeks of life, and occasionally are extensive and multiple. This condition may occur sporadically in several members of a family as an autosomal dominant trait. Again, histological examination is useful (absence of epidermis) when other diagnostic possibilities exist.

Herpes Simplex

When blisters are noted on the newborn's skin or mucosa, herpes simplex must be ruled out by Wright or Giemsa (giant cell) preparation because of the serious consequences of the illness. An interesting mnemonic is the "Rule of Halves"—about half the children born to mothers with active genital herpes simplex will contract the disease, half the newborn with herpes simplex neonatorum have skin manifestations, and half these children die. Because the incidence of venereal herpes simplex has increased in the past ten years, herpes simplex neonatorum is more prevalent than previously.[5] Skin lesions may be found anywhere but most often on the scalp and face since these areas have the closest and longest contact with the cervical area from which the disease is transmitted under normal circumstances of childbirth.

Another viral disease with skin manifestations is the congenital rubella syndrome which presents with blueberry-like lesions at the sites of extramedullary hematopoiesis.[6] Similarly appearing lesions are seen in newborn with cytomegalic inclusion disease and in metastatic neuroblastomas, the most common malignant tumor of the newborn.

Pigmented Nevi

Pigmented nevi are present in less than 3% of newborns; however, the giant pigmented nevus, also called bathing trunk or garment-like nevus, is almost always present at birth.[7] Melanomas form in some 10% to 20% of these nevi, often in the very early years; therefore, they should be removed as early as surgically tolerable. Ominous-looking sites, where color or growth changes occur, should be biopsied as early as possible.

Nevus Sebaceus of Jadassohn

Nevus sebaceus of Jadassohn is a yellow-orange plaque of hypertrophied sebaceous glands occurring on the scalp and less often on the face. These growths are removed cosmetically and prophylactically at puberty since about 30% give rise to sweat gland or basal cell tumors. Squamous cell and sebaceous cell carcinomas arising from these nevi have been reported in children less than five years of age.[8] Because such carcinomas may metastasize, it becomes important to remove or biopsy ulcerated, nodular or suspicious growth within nevus regardless of the patient's age.

Sclerema

Diseases affecting the subcutaneous fat of the newborn are not common. Sclerema is a serious disease in which subcutaneous fat induration causes the skin to feel hard at birth. It may be fatal even though biopsy changes are minimal. Premature infants with preexisting disease are most commonly affected. The therapy of choice is to maintain normal body temperature, a tactic which saves about half these infants.

Subcutaneous fat necrosis unlike sclerema which begins in the first week of life usually begins in the first few months, has a benign prognosis, and is self-limiting. The hard plaques and nodules are usually violaceous but resolve over a period of weeks to months. Histopathological sections reveal granulomatous reactions in the subcutaneous tissues. Therapy is seldom needed but the physician must distinguish between the benign localized form and the

more serious general involvement of subcutaneous fat.

Current Problems

Some current problems in pediatric dermatology are important as well as revised notions and difficult new areas of clinical advances.[9,10] An example is Leiner's disease which heretofore was considered a severe variant of seborrheic dermatitis associated with diarrhea.[11] Recent investigation has revealed that the C5 component of complement may be defective in these patients.[12] There is interference in the complement's ability to opsonify yeast organisms. Several patients have been successfully treated with fresh plasma infusions; in some the disease has been self-limited and improvement gradually occurs. Since relatives also have the defect, it is not known why some of them fail to have the disease nor why infants with it may recover with time.

Another condition which may be the result of deficient complement, often the C2 component, manifests as a familially inherited or congenital systemic lupus erythematosus.[13] The finding of complement deficiencies may open the door to further diagnostic and therapeutic possibilities for this unusual group of patients.

Several diseases are being defined by the complement defect or deficiency with which they are associated. Forms of Clr, Cls, C4, and C5 deficiencies recently have been described as a recessively inherited syndrome. A clinical feature is a solar sensitivity rash which is found in less than 50% of the usual LE patients with this symptom complex.

The pediatric dermatologist of tomorrow may request that physicians use agents other than Dilantin or other hydantoins to treat the seizure disorder associated with adenoma sebaceum. Fibrosis is the common denominator of this disease and the heart, kidneys, brain, lungs, bones, and other areas eventually become involved. These drugs enhance or increase fibrosis as they decrease collagenase activity (as do estrogens). This problem needs close study and is one avenue which gives direction to the future of pediatric dermatology.

References

1. Hidano, A., and Nakahma, A.: Earliest Features of Strawberry Mark in Newborn, Brit. J. Derm. 87:138-144, 1973.
2. Cohen, S. R., and Wang, C. I.: Steroid Treatment of Head and Neck in Children, Ann. Otol. Rhinol. Laryng. 81:584-590, 1972.
3. Davis, W.: Superficial Radiation Therapy for Klippel-Trenaunay-Parkes-Weber Syndrome, Proc. Radiol. Soc. Meet., Montreal 1973.
4. Oppenheimer, E. H., and Hardy, J. B.: Congenital Syphilis in Newborn Infant. Clinical and Pathological Observations in Recent Cases, Hopkins Med. J. 129:63-82, 1971.
5. Amstey, M. S.: Incidence of Herpes VD, 3rd Int. Venereal Dis. Symp., New Orleans 1973.
6. John, R. W., and Tobin, J. H.: Neonatal Herpesvirus Hominus Infections, Postgrad. Med. J. 49:380-382, 1973.
7. Bergfield, W., and Helwig, E.: Congenital Giant Nevus. An Exhibition, Amer. Acad. Derm., Bal Harbour 1973.
8. Constant, E., and Davis, D.G.: Premalignant Nature of Sebaceous Nevus of Jadassohn, Plast. Reconst. Surg. 50:257-259, 1972.
9. Kahn, G.: Pediatric Dermatology, Part 1, pp. 1-5, 45-47, MedCom Famous Teachings in Modern Medicine, New York 1973.
10. Kahn, G.: Pediatric Dermatology, art, pp. 6, 54, MedCom Famous Teachings in Modern Medicine, New York 1973.
11. Jacobs, J. C., and Miller, M. E.: Fatal Familial Leiner's Disease. Deficiency of Opsonic Activity of Serum Complement, Pediatrics 49:225-232, 1972.
12. Winkelstein, J. A.: Opsonins: Their Function, Identity, and Clinical Significance, J. Pediat. 82:747-753, 1972.
13. Moncada, B.; Day, N. D. B.; Good, R. A., and Windhorst, D. B.: Lupus Erythematosus-Like Syndrome with Familial Defect of Complement, New England J. Med. 286:689-693, 1972.

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A MEASURING ROD

That best portion of a good man's life.
His little nameless unremembered acts
Of kindness and of love.

—William Wordsworth

The Rational Approach to Acne Vulgaris

Stephen H. Mandy, M.D.

Acne is a socially crippling disease often leading to permanent disfigurement which affects 80% of the adolescent and young adult population. Although most patients attempt various forms of proprietary treatment, only 25% actually seek professional help. While the most severely affected patients eventually come to a dermatologist, the majority are treated casually by their family physicians or other specialists incidental to another illness. The casual attitude of many physicians toward acne reflects the patient's reluctance to focus attention upon his defect. Actually this laissez-faire attitude, in fact, is representative of social denial and the patient's substantial concern for this problem. Yet, effective, inexpensive, safe and rational therapy for acne is readily available, and can lead to a dramatic social and psychological transformation in many afflicted youngsters. Successful therapy depends upon a complete understanding of the pathophysiology of acne and correlating pathogenesis with the clinical presentation of each individual patient.

Pathogenesis

The primary pathological process leading to development of acne is "retention hyperkeratosis." This is a retention of the cells of the ductal epithelium at its isthmus near the terminal pore as well as keratin debris within the sebaceous follicle. This leads to obstruction of the sebaceous duct and accumulation of sebum in the acini and lower duct beneath the surface of the skin. Normally, the follicular epithelium sheds continuously to maintain patency of the lumen, but apparently in individuals with acne an autosomal dominant trait sets the stage for retention hyperkeratosis. The developing lesion eventuates into an open or closed comedo which may remain constant in size or enlarge to break down from resulting inflammation. This in turn may result in an inflammatory papule or cyst. In spontaneously occurring endogenous acne, an increase in circulating testosterone during adolescence is the usual inciting factor causing sebaceous gland hypertrophy with a resulting increase in sebum production. The triglyceride component of sebum provides an ideal substrate to culture the bacteria. Corynebacterium acnes, which inhabit the follicles. These bacteria break down the triglycerides into free fatty acids and glycerol by means of its enzyme, lipase. The free fatty acids then act as irritants to the follicle. This probably perpetuates the retention hyperkeratosis as well as the inflammation about the resulting lesion. The comedogenic potential of C. acnes, free fatty acids and sebum itself has been demonstrated but at this time the relationship of each to the total picture of acne is not entirely clear. It is sufficient to say that all these factors, combined with retention hyperkeratosis, lead to comedones, which may evolve into inflammatory papules, pustules, and/or cysts which when healed will leave a scar as lasting evidence of their activity (Fig. 1).

Related Factors

Many external and internal factors can influence the pathogenesis of acne. Dietary studies have failed to demonstrate foods as prominent influences. Climate is most important with hot, moist climates causing severe exacerbation in many patients. Although sun (ultraviolet light) is often beneficial, its benefits are sometimes countered by heat and sweating. Excessive physical and emotional stress will often flare acne, and it is common to see an "epidemic" of acne during final examinations or competitive performances. Externally applied cosmetic agents, especially those containing fatty acid esters, will often aggravate and in some patients initiate acne. This is particularly common in the 20 to 40 age group of women. However, the psychological benefits of a lipid-free cover makeup often outweighs any deleterious effect. "Pommade acne," usually seen on the forehead in black patient's, results from the use of greases on the hair and is similar to "oil folliculitis" seen in some mechanics. It is well known that prolonged use of systemic steroids, iodides, and topical steroids on the face in acne-prone patients can produce acne which only differs clinically by the small pustules and uniform size of the lesions. True comedones are sparse. Steroid and iodide acne usually responds to the same therapy as acne vulgaris after cessation of the drug.

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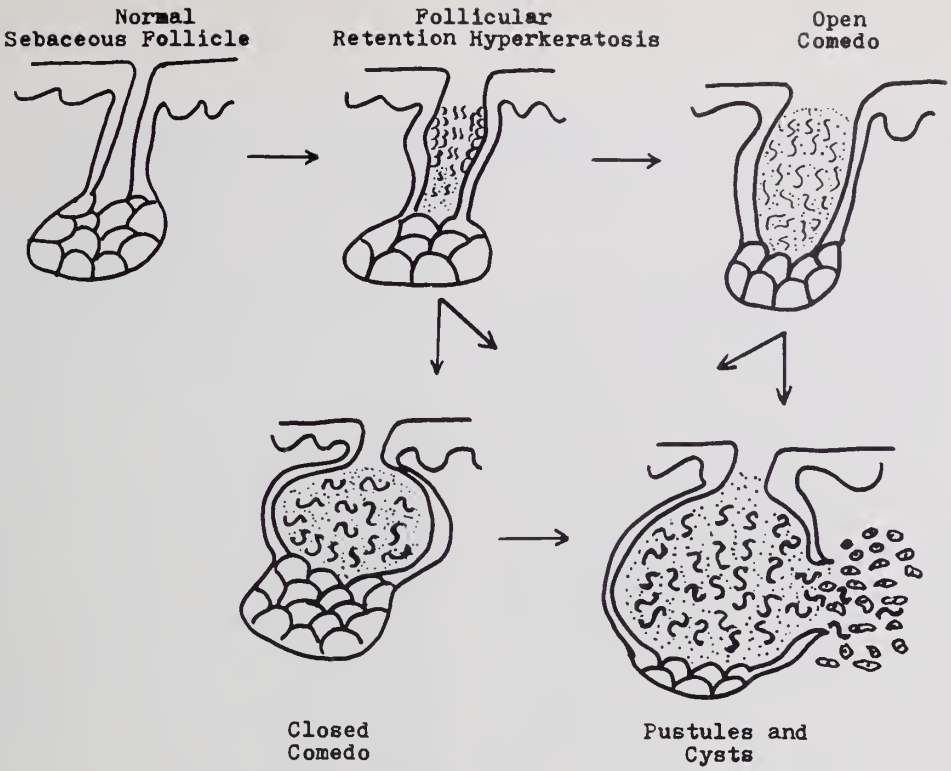


Fig. 1.—The normal sebaceous follicle, under hereditary and hormonal influence, hypertrophies leading to follicular retention hyperkeratosis. This, by obstructing the lumen, leads to open and closed comedo formation and these lesions, inhabited by C. acnes, lead to inflammatory papules, pustules and cysts.

Staging Acne

Determining the stage or level of acne in a given patient is helpful in making a decision as to which agent or combination of agents will be most useful in treatment. Classification is relatively simple with Grade I acne consisting primarily of sparse comedones ranging to Grade IV being full blown, inflamed cystic acne. Grades II and III are intermediates usually judged by the number and inflammatory component of the lesions.

Tropical Treatment

Tretinoin—Vitamin A acid is a potent stimulator of epidermal cell turnover increasing it to approximately six times normal. This decreases the thickness and cohesiveness of the stratum coreum and tends to unseat follicular plugs (comedones) by inducing a "follicular flush." As a topical agent, it has a wide margin of safety. It must be used consistently and sparingly to avoid persistence of the initial irritation. The 0.05% saturated pad is the most potent and irritating. It is usually reserved for patients with dark complexions, oily skin and more severe acne. The 0.1% cream is less irritating and preferred in moderate acne. Grades I and II acne usually responds to the weaker 0.05% cream. Tretinoin is usually applied sparingly to the entire face once a day before retiring. Face washing with this treatment should be minimal using gentle soaps. Sun exposure must be limited or blocked by screening agents since tretinoin increases photoreactivity.

Benzoyl peroxide—This is a milder stimulant to epidermal cell turnover than tretinoin but has the added advantage of being antiseptic. It kills C. acnes quite effectively and usually shows improvement in two to four weeks. Benzoyl peroxide is also an irritant initially and will induce mild erythema and peeling for several weeks until adaptation occurs. Contact dermatitis is seen occasionally requiring discontinuance of treatment. Benzoyl peroxide is applied sparingly initiating treatment with a 5% lotion or gel once a day. Later it can be applied twice daily and, if well tolerated, the 10% preparation can be used. Occasionally tretinoin and benzoyl peroxide can be used together first starting tretinoin alone for two to three weeks then applying them at different time intervals. More drying can be tolerated by acne patients in the warm moist climate of Florida than in the cold, drier environments of the north. Negro skin, however, does not tolerate excessive drying.

Irritants

Many sulfur-containing soaps, gels and lotions are available as nonprescription items and are somewhat effective in milder grades I and II acne. Their peeling effect, by means of irritation, is nonspecific and of less value in the more severe cases. They should not be used early in the course of tretinoin or benzoyl peroxide treatment as they compound the problem of irritation and patient acceptance. Astrin-

gents, sunlight, acid peels, and abrasive soaps act similarly and should not be used aggressively in conjunction with tretinoin or benzoyl peroxide.

Systemic Therapy

A variety of antibiotics have been used in the treatment of more inflammatory forms of acne. These, it is presumed, quantitatively diminish C. acnes within the follicle and reduce their "invasiveness" thereby decreasing the free fatty acid production and subsquent inflammation. Tetracycline is by far the most widely used since it has the greatest safety and is the least expensive. Therapeutic dosage ranges from 500 mg. to 2 grams per day, depending on the severity of the problem. Since antibiotics do not, in effect, alter the basic pathology of retention hyperkeratosis, they should not be used alone but in conjunction with effective topical therapy. Once the retention hyperkeratosis is controlled by topical treatment the tetracycline can usually be decreased or discontinued. Erythromycin, clindamycin, and lincomycin have also been used successfully but the expense and potential hazards—especially with clindamycin—tend to discourage their use.

Estrogens have been shown to diminish sebum production and in female patients low-dose estrogen-dominant oral contraceptives are often of benefit in acne. The use of estrogen in males is rarely indicated because of the potential feminizing side effects. Steroids may reduce the massive destruction and inflammation seen in acne conglobata.

Other Modalities

Cryotherapy with liquid nitrogen or freezing of cystic lesions with CO_2 sludge to induce peeling are used as adjunctive therapy in some patients. Their effects are temporary but often immediate and can be used to give a more prompt response when beginning therapy. Injection of steroids, usually triamcinolone, into inflammatory cysts will often give dramatic resolution of lesions. This should be done with caution, however, as atrophy of the area is a disconcerting and not infrequent residual effect, but even this atrophy usually resolves in time. X-ray therapy was commonly used for acne in years past but time proved many ill effects developed on the x-ray exposed skin such as accelerated solar sensitivity, atrophy and keratotic or carcinomatous degeneration. Presently, some dermatologists experienced in x-ray therapy still reserve this modality for severe cystic acne or acne conglobata.

Summary

A rational approach to combined therapy begins with patient education. Dispelling "old wives tales" about cleanliness, excessive dieting and vitamins plus concern and understanding on the part of the physician have immeasurable benefits in acne. In carefully controlled studies, a 50% placebo response which is most certainly "physician effect" is not unusual. Once the grade of acne is determined, the agents to be used are selected according to the clinical presentation. For light complexioned patients with mild acne, the lower strength topical agents alone are usually sufficient. The darker the complexion and the more severe the acne, the better tolerated (except in black patients) are the stronger agents. For patients with grades III or IV acne, tetracycline is used along with topical agents. Topical therapy allows progressive decreases in tetracycline dose schedules as the patient improves. Once clearing has been achieved, especially in adolescent acne, maintenance therapy with tretinoin, benzoyl peroxide, or other drying agents may be continued for six months to years or possibly until the patient is beyond adolescence.

When patients understand the nature of their problem and the fact that treatment takes time for good results, usually they will be cooperative and enthusiastic. One who approaches acne armed with the basic knowledge of its pathogenesis while gradually adding agents to correct follicular hyperkeratosis and eliminate C. acnes will usually be successful. Perseverance with few agents over several months is more likely to achieve success than frequent changes in medication. Early active and effective treatment of acne is a minimum investment to avoid scars and social withdrawal that often last a lifetime.

Trade Names

1. Tretinoin—RETIN-A®—Johnson & Johnson
 0.05% saturated pads
 0.1% cream
 0.05% cream
 0.02% gel
2. Benzoyl peroxide (5% and 10%)
 PanOxyl gel, Benoxyl lotion—Stiefel
 Desquam-X gel—Westwood
 Benzagel and Vanoxide lotion—Dermik
 EPI*CLEAR—Squibb
 Persadox—Texas Pharmacal

References

1. Mills, O. H.; Marples, R. R., and Kligman, A.M.: Acne Vulgaris—Oral Therapy with Tetracycline and Topical Therapy with Vitamin A Acid, Arch. Derm. 106:200, 1972.
2. Logan, W. S.: Vitamin A and Keratinization, Arch. Derm. 105:748, 1973.
3. Mandy, S. H.: Art of Tretinoin Therapy in Acne, Cutis 14:855, 1974.
4. Pace, W. E.: A Benzoyl Peroxide Sulfur Cream for Acne Vulgaris, Canad. Med. Ass. J. 93:252-254, August 1955.

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Alopecia

George Ioannides, M. D.

Broadly and imprecisely the term alopecia commonly refers to dissimilar conditions of the hair, some normal and some abnormal, most often not reflecting actual loss of hair follicles or numbers of hairs. Considered mainly a cosmetic problem throughout history, it has become a professional liability factor as well.

A review of basic events in the hair follicle's life will help in understanding what happens in various forms of alopecia.

Normal Hair Follicle

During the human embryo's second and third months, approximately 2 million hair follicles develop as downgrowths of basal parts of the undifferentiated epidermis.[1] New hair follicles do not develop in adults.[2] A mass of germinative cells, i.e., hair matrix, in the center of the deep end (bulb) of each follicle, provide new cells through successive divisions, thus resulting in hair growth.

Each follicle has a period of growth called the anagen phase; of cessation of growth, the catagen phase, and of matrix involution, the telogen phase. As a rule during the **anagen phase** the follicle root is long and deeply anchored in the subcutaneous fat or deep dermis; the junction of matrix and lower end of the hair shaft, the latter consisting of young, maturing epithelial cells, is strong. A few layers of cells above the matrix, the hair cells become keratinized so that each hair on the body's external surface is fully keratinized. During the brief **catagen phase** the follicle gradually becomes shorter and more superficially located within the dermis. Finally during the **telogen phase,** the follicle is shortest and most superficially located in the dermis; the hair's deep end (root) becomes enlarged, club-shaped, and totally keratinized by the addition of keratinized cells deriving from the follicle's outer root-sheath. The junction of the hair's root with the cells of the deep end of the parent follicle is weak, and the hair may detach easily by combing, other kinds of external friction or because of displacement by the new hair produced by a new matrix in the reactivated follicle. This shedding marks the end of the telogen phase and the beginning of the next anagen phase in the follicle's continuing life.

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All hairy animals exhibit cyclical activity of the follicles.[2,3] Poodle dogs and Merino sheep do not have telogen-hair shedding, because their life span is shorter than the anagen phase of the follicle cycle.[3] Other animals, known to replace their coat annually, shed the hairs at a certain time of the year, because their follicles enter the telogen phase almost simultaneously.[2] The hair follicles of the man are individualistic, each having its own time schedule for the cycles of growth. Therefore, in a given area of the body one can find hair follicles in the three phases of the hair cycle (mosaic pattern). Plucking hairs of the scalp, placing their roots in water, and examining them with a hand lens for the determination of the anagen and telogen counts is one of the dermatologic methods of investigation of conditions of the hair, especially in the scalp.

Despite differences in quality of hairs, there is no significant variation between men and women in the number of hair follicles.[4]

In the average human scalp there are 100,000 hairs or follicles,[5] about 85% in the anagen phase, few in the catagen phase, and about 15% in the telogen phase.[3] During the anagen phase, approximately 3.7 years, each matrix cell divides once in 24 hours,[6] each hair grows 0.37 mm. per day,[7] and may become 50 cm long by the time of telogen shedding. The telogen phase of the scalp hair lasts approximately three months.[3] In a given day 70 follicles enter the telogen phase, 70 the anagen phase and, therefore, 70 hairs are shed from the scalp of the average individual.[3]

Human hairs are terminal and vellus. Terminal hairs (scalp, beard) are long, thick, pigmented, and seen with the unaided eye. Vellus hairs are short, thin, poorly pigmented, and not easily seen. For example, extensive areas of the body covered with vellus hairs such as the forehead are commonly considered hairless. Hair follicles of the scalp are distributed in small groups. Each group has two to five terminal and one to three vellus hairs.[3] Of these, however, it is the terminal hairs that we observe in order to determine whether or not a person is bald.

Mechanisms Leading to Alopecia

Clinically, alopecia denotes that a given area of the skin surface has less than the normally expected amount of hair as judged by the unaided eye. Therefore, the term practically means "less than expected

terminal hair concentration." Patients with alopecia account for 3% to 8% of new outpatients at most dermatologic clinics in Europe.[8]

An area of the skin may have alopecia because of one or more of the following reasons:

1. Aplasia of hair follicles in utero leading to two forms of irreversible alopecia: congenital atrichia when the aplasia is total in the affected area and hypotrichia when the aplasia has occurred in only some hair follicles. Congenital atrichias or hypotrichias of the scalp are rare and may occur in association with other ectodermal defects such as dystrophy or absence of the nails.[3]

2. Destruction of hair follicles by disease followed by fibrous-tissue replacement leading to irreversible scarring or cicatricial alopecias.

3. Excessive shedding of hairs from otherwise normal hair follicles due to excessive proportion of follicles having entered the catagen and then the telogen phase. Such shedding due to an increase in the telogen/anagen ratio is referred to as "telogen effluvium" and represents a nonspecific response of the hair follicles to stress.[5] The stress of birth on the newborn, certain inflammatory dermatoses, drugs, acute febrile or psychiatric diseases, and spontaneous or iatrogenic hypothyroidism[9] are among the known inducers of telogen effluvium. In the scalp, telogen counts higher than 25% are considered diagnostic of telogen effluvium.[5]

4. Regression of terminal hair follicles to vellus hair follicles. This phenomenon is a dominant feature in common baldness or male-pattern alopecia. It is the reverse of what occurs in the beard of men after puberty when the vellus follicles become terminal to produce the adult beard.

5. Arrest of the follicles in the early anagen phase as seen in alopecia areata where the produced anagen hairs are short, thin, and colorless ("anagen effluvium").

6. Decrease in mitoses of the hair matrix cells caused by antimitotic drugs or x-rays resulting in thin and brittle intrafollicular segments of anagen hairs and, therefore, effluvium of anagen hairs.

7. Interference with protein synthesis in the hair-forming cells of the follicles as in thallium poisoning, iron and B_{12} deficiencies, chronic neoplastic disease, and systemic lupus erythematosus may result in formation of brittle and, therefore, easily shed anagen hairs.

8. Mechanical (traction) hair loss as seen in trichotillomania, ponytail and other hair styling. As long as the hair bulb is able to regenerate, new hair matrix and shaft will be formed in each affected follicle.

Clinicopathologic Forms of Alopecia

Aside from the irreversible rare congenital alopecias already mentioned, the various clinicopathologic forms of alopecia may be divided into two groups: those with preserved hair follicles which suffer a physiologic disturbance the duration of which determines the duration of potentially reversible alopecia, i.e., nonscarring alopecias, and those with irreversible fibrous-tissue replacement of destroyed hair follicles, i.e., scarring alopecias.

Nonscarring Alopecias

Neonatal Alopecia

Apparently due to the stress of birth, a high proportion of hair follicles may enter the telogen phase resulting in the physiologic shedding of hairs (telogen effluvium) at varying times from immediately after birth to age four months.[5] Reported telogen counts vary from 4% to 87%.[5] As soon as new anagen hairs develop, the alopecia disappears.

Postpartum Alopecia

During the second and third trimesters of pregnancy, many follicles may remain in the anagen phase instead of duly entering the telogen phase.[10] In the first postpartum days, such follicles enter the telogen phase simultaneously and raise the telogen counts from the normal 15% to an average of 30%.[3,5] The physiologic shedding (telogen effluvium) occurs one to five months after delivery,[11] lasts for two to five months[5] and is regularly followed by the anagen phase and disappearance of the alopecia.

Alopecia from Oral Contraceptives

Nonscarring alopecia may develop during and after administration of oral contraceptive drugs.[12] That occurring during administration resembles male-pattern alopecia and that developing after discontinuance is due to telogen effluvium. Alopecia from oral contraceptives may complicate or be complicated by other types of diffuse hair loss in women.

Common Baldness (Male-Pattern Alopecia)

By far more frequently seen in men than in women and not occurring in males castrated before puberty, common baldness seems to be dependent on such factors as aging, heredity (autosomal dominant), and androgens.[8] Initially an increase in telogen counts and telogen shedding take place. Gradually, over successive cycles, the size of the follicles becomes reduced, the size of the matrices proportionately reduced,[13] and the long terminal hairs regress into the short, fine, and colorless vellus hairs.[14] Only

in the very advanced stage, the vellus follicles disappear. The epidermis becomes atrophic. The epidermal and hair-follicle melanocytes become atrophic and produce only scanty melanin.[3] The amount of sebum produced remains within normal limits. The number of sebaceous glands is reduced but the size of each gland appears increased. The sweat glands remain unchanged. The dermis contains increased amounts of sulfated mucopolysaccharides.[8]

Alopecia Areata

This mysterious form of alopecia, which affects men and women alike,[15] accounts for 2% of new dermatologic outpatients in the United States and Britain,[8] and has an estimated incidence of 1:10,000 in the general population.[11] The first attack most often occurs between the ages of five and 40 years.[10] Asymptomatic, well-circumscribed, round or oval, smooth, white patches of total alopecia, without evidence of inflammation or scarring, may appear in such areas as the scalp, eyebrows, beard, arms and legs. Within a few weeks great proportions of the scalp may become bald. The alopecia may involve all of the scalp, i.e., alopecia totalis, or the entire body, i.e., alopecia universalis. When spontaneous resolution occurs, usually the hair appears first in the center and then the periphery of the affected areas. In the early stage, the deep parts of the hair follicles are surrounded by lymphocytes loosely arranged like a "swarm of bees." Gradually the follicles become arrested in the early anagen phase, being short, thin, and superficially located in the dermis.[16] The concentration of matrix melanocytes is reduced. The arrested anagen follicles produce short, thin, nonpigmented hair shafts which are not evident clinically (anagen effluvium). Occasionally when some of such hair shafts contain melanin pigment, the pigmented thin short hairs appear as "black dots" on the white surface of the affected area, thus simulating the "black dot" lesions of some forms of tinea capitis.

Several studies have suggested interrelationship of alopecia areata with Hashimoto's thyroiditis, pernicious anemia, adrenal disease, vitiligo, and atopy.[17] Also statistical significance has been established between alopecia areata and presence in patients' serum of circulating antibodies against thyroglobulin, parietal cells of the stomach, adrenal cells, and thyroid cells.[17]

Drug Alopecias

Thallium, accidentally taken (as in rat poisons) or given to children with tinea capitis for depilation, interferes with cystine incorporation into keratin resulting in formation of brittle intrafollicular segments in the anagen hairs. Such segments easily break and the hairs shed one week after thallium ingestion (anagen effluvium). One week following the onset of the effluvium, 80% of the follicles are found in the catagen phase. Thallium can be demonstrated in the urine and stools for five or more months after poisoning.[18]

Antimitotic drugs, used for treatment of psoriasis and neoplasms and suppression of homograft reactions, can cause standstill in mitoses of hair matrix cells resulting in formation of thin intrafollicular segments in anagen hairs. Such segments will easily break and the hairs will shed (anagen effluvium).[3]

Colchicine may cause anagen effluvium by a mechanism similar to that of the antimitotic drugs[3] in addition to telogen effluvium.[19] Colchicine alopecia occurs two to three weeks after administration of relatively large doses of the drug and persists from two weeks to three months.[19]

Anticoagulants. Heparin and coumarin may induce the telogen phase in excessive numbers of follicles and, therefore, result in telogen effluvium usually about three months after initiation of the anticoagulant treatment.

Skin Diseases

Generalized exfoliative dermatitis, seborrheic dermatitis and psoriasis may cause temporary alopecia either by inducing telogen effluvium or by producing thin, easily fracturing hairs.[3]

Acute Diseases

Sometimes, acute febrile illnesses (influenza), psychiatric illnesses (schizophrenia), acute anxiety or depression may precipitate a typical telogen effluvium. Telogen counts as high as 54% have been found in the scalp of patients with postfebrile and psychogenic telogen effluvium.[5]

Chronic Diseases

Systemic lupus erythematosus and neoplastic disease with cachexia may be associated with nonscarring alopecia,[3] probably due to deficiency in protein metabolism.

Miscellaneous Forms

Reversible nonscarring alopecias may accompany infections (secondary syphilis, leprosy, tinea capitis), deficiency states (iron deficiency from chronic bleeding, gastrointestinal, uterine, etc., low vitamin B_{12}), endocrine diseases (hypothyroidism or myxedema, hypopituitarism or Simmond's disease) or they may be caused by traction (trichotillomania, ponytail styling), x-ray radiation, and chemical agents (thioglycollates used for permanent waves).

Scarring Alopecias

A variety of situations exist in which destruction of hair follicles is followed by fibrous tissue replacement and irreversible scarring alopecia.

Infective Folliculitis

Folliculitis with destruction of hair follicles and irreversible scarring alopecia may occur in sites of fungous (favus, kerion), bacterial (carbuncle, folliculitis decalvans), viral (zoster), spirochetal (late syphilis) and other infections.

Physical Agents

Follicular destruction may be caused by thermal burns, freezing, and x-rays. Irreversible alopecia of the scalp occurs in Negro women who straighten their hair with hot combs and petrolatum. This method of styling causes chronic follicular inflammation, destruction and fibrous-tissue replacement.[20]

Chemical Agents

Caustic materials such as acids and alkalis may result in scarring alopecias.

Nevi and Neoplasms

Congenital tumor-like malformations of the skin (e.g., nevus sebaceus of Jadassohn) may be hairless from the beginning. Neoplasms of the skin (e.g., sclerosing-type basal cell carcinoma or cutaneous metastatic carcinoma) may present as a plaque of irreversible alopecia (alopecia carcinomatosa).

Special Diseases

Many patients presenting with scarring alopecia, especially of the scalp, may have hair follicles destroyed by the characteristic processes of such recognized diseases as lupus erythematosus, lichen planus (pilaris, atrophic), scleroderma (morphea, linear, systemic), sarcoidosis, and keloids. The clinical history, physical examination, biopsy and various other laboratory investigations as a rule are parts of the dermatologic workup of these patients.

Not infrequently, however, there are instances in which one cannot find evidence of conditions known to cause scarring alopecia. In such cases of idiopathic cicatricial alopecia many have been using the term alopecia cicatrisata (or pseudopelade) of Brocq. Others, however, define pseudopelade as a morphologic syndrome which may be attributed to a known pathologic process in 70% of cases, the remaining cases being considered as pseudopelade of unknown origin.

Pseudopelade begins insidiously as round or oval, smooth, white, slightly depressed areas of baldness, measuring less than 1 cm in diameter and appearing singly or in groups. Typically there are no signs of inflammation. Only slight erythema may be seen in the early stage. Neighboring patches tend to coalesce and irregular plaques of alopecia several centimeters in diameter may be formed. Scattered follicles in these plaques are often spared. Biopsy of early lesions may show lymphohistiocytic infiltrates around the upper parts of the hair follicles, sparing the lower parts. Later the pilosebaceous units cannot be found, their sites being marked by fibrosis and the remaining arrectores pilorum muscles. The sweat glands remain intact.

Comment

The differential diagnosis of alopecia is not simple. It requires the knowledge, skills and experience of the dermatologist. He will study the clinical history, pattern of disease, state of the skin surface, spontaneously shed and plucked hairs, various laboratory findings and, when indicated, the biopsy specimen before he makes a decision as to the correct diagnosis, prognosis and treatment.

References

1. Pinkus, H.: Embryology of Hair, in Biology of Hair Growth, Montagna, W., and Ellis, R. A., eds., Academic Press, New York, 1958, pp. 1-32.
2. Montagna, W.: Structure and Function of Skin, 2nd ed., Academic Press, New York and London, 1962, pp. 174-263.
3. Munro, D. D.: Disorders of Hair, in Dermatology in General Medicine, Fitzpatrick, T. B., et al., eds., McGraw-Hill, New York, 1971, pp. 299-331.
4. Szabo, G.: Regional Frequency and Distribution of Hair Follicles in Human Skin, in Biology of Hair Growth, Montagna, W., and Ellis, R. A., eds., Academic Press, New York, 1958, pp. 33-38.
5. Kligman, A. M.: Pathologic Dynamics of Human Hair Loss, I. Telogen Effluvium, Arch. Derm. 83:175-198, 1961.
6. Van Scott, E. J.; Ekel, T. M., and Auerbach, R.: Determinants of Rate and Kinetics of Cell Division in Scalp Hair, J. Invest. Derm. 41:269-273, 1963.
7. Myers, R. J., and Hamilton, J. B.: Regeneration and Rate of Growth of Hairs in Man, Ann. N.Y. Acad. Sci. 53:562-568, 1951.
8. Ebling, F. J., and Rook, A.: Hair, in Textbook of Dermatology, Rook, A.; Wilkinson, D. S., and Ebling, F.J.G., eds., 2nd ed., Blackwell, Oxford, 1972, pp. 1559-1641.
9. Freinkel, R. K., and Freinkel, N.: Hair Growth and Alopecia in Hypothyroidism, Arch. Derm. 106:349-352, 1972.
10. Lynfield, Y. L.: Effect of Pregnancy on Human Hair Cycle, J. Invest. Derm. 35:323-327, 1960.
11. Jelinek, J. E.: Cutaneous Side Effects of Oral Contraceptives. Arch. Derm. 101:181-186, 1970.
12. Cormia, F. E.: Alopecia from Oral Contraceptives, JAMA 201: 635-637, 1967.
13. Van Scott, E. J., and Ekel, T. M.: Geometric Relationships Between the Matrix of Hair Bulb and Its Dermal Papilla in Normal and Alopecic Scalp, J. Invest. Derm. 31:281-287, 1958.
14. Ellis, R. A.: Aging of Human Male Scalp, in Biology of Hair Growth, Montagna, W., and Ellis, R. A., eds., Academic Press, New York, 1958, pp. 469-485.
15. Muller, S. A., and Winkelmann, R. K.: Alopecia Areata, an Evaluation of 736 Patients, Arch. Derm. 88:290-297, 1963.
16. Van Scott, E. J.: Morphologic Changes in Pilosebaceous Units and Anagen Hairs in Alopecia Areata, J. Invest. Derm. 31:35-43, 1958.
17. Kern, F.; Hoffman, W. H.; Hambrick, G. W., Jr., and Blizzard, R. M.: Alopecia Areata, Immunologic Studies and Treatment With Prednisone, Arch. Derm. 107:407-412, 1973.
18. Arnold, W.; Herzberg, J. J.; Ludwig, E., and Stude, H.: Die Dynamik des Haarausfalls beix Thallium-Vergiftung. Eine Korrelation Klinischer, histologisher und toxicologischer Befunde, Arch. Klin. u. exp. Derm. 218:396-414, 1964.
19. Malkinson, F. D., and Lynfield, Y. L.: Colchicine Alopecia, J. Invest. Derm. 33:371-384, 1959.
20. Lo Presti, Ph.; Papa, Ch. M., and Kligman, A. M.: Hot Comb Alopecia, Arch. Derm. 98:234-238, 1968.

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Successful Hair Transplant Surgery
A Composite Evaluation

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Hair transplantation is a surgical office procedure for treatment of baldness. It is accomplished by actually moving full thickness grafts or "plugs" of hair-bearing skin from the posterior and lateral scalp to bald areas on top of the head. Each graft is about 3 or 4 mm. in diameter and, depending on the individual, may contain six to 18 hairs each. This technique is effective in multiple types of baldness, specifically: (1) male pattern baldness, the "M-shaped" recession of hair common in men; (2) baldness for scars due to accidents, operations or radiation, and (3) baldness due to inflammatory or infectious diseases of the scalp.

There is no question that the procedure "works" when performed by competent hands. It has been a recognized technique for over 20 years, having been originated by a New York City dermatologist, Norman Orentreich. The technique has been refined and improved by other dermatologists and more recently by overlapping specialists. Today it is accepted by the medical community as an effective treatment for baldness. As with any cosmetic procedure, proper execution is a blend of artistry and science. The expertise, training and talent of the surgeon are all reflected in the quality of the results.

The surgery is almost always performed in the office after an initial consultation. At the time of consultation the physician must establish the suitability of the surgical candidate. A detailed history of general health, medications, allergies, psychiatric problems and evaluation of the patient's self-image and surgical expectations are all noted. Specific attention to scarring or bleeding tendencies is also recorded and routine preoperative blood work is performed. The patient is then examined in terms of scalp disease as well as the quality and quantity of the hair available as donor grafts. A close approximation of the proposed hairline is drawn on the patient's scalp with a wax pencil. The number of grafts required and an approximation of the total cost are then discussed. Visual aids showing "before" and "after" photographs, "good" versus "poor" results, and various styling suggestions all help the patient understand the technique and leave little room for misunderstanding or future dissatisfaction. After a surgical date has been arranged, the patient is given a list of preoperative instructions. The preparation itself is actually quite simple. The hair is shampooed the evening before or morning of the procedure. He is advised not to drink alcoholic beverages or take aspirin for 24 hours preceding the surgery. Also, the patient should not have a haircut for at least two weeks before the procedure. Since the donor site is trimmed at the time of surgery, it is more easily camouflaged if the surrounding hair is not short.

The procedure is performed in a well-equipped surgical suite with adequate emergency facilities. The donor area is anesthetized with lidocaine and epinephrine. The desired number of grafts are then removed with a special 4 mm. skin punch of precision sharpness. Careful attention is paid to the instrument's cutting exactly parallel to the direction of the hair shafts. If hair shafts are transsected by malalignment, the growth in the graft will be obviously diminished. The donor grafts are carefully cleaned in sterile saline, their excess fat is trimmed and they are meticulously examined for adherent hair spicules which might cause a foreign body rejection if carried with the graft to the recipient site.

Next an equal number of hairless grafts (each 0.5 mm. smaller in diameter than the donor grafts) are taken from the bald area and discarded. These recipient sites are placed about 5 mm. apart and the donor grafts are then placed into them. Attention is paid to hair direction and angulation of the graft in its recipient site. Each graft should fit snugly but not be forced or jammed into place. If the site is too small for the graft, a cobblestone effect will follow and the hair may grow in a kinky manner. If the recipient site is too large for the graft, an obvious

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scarred margin will surround the periphery of each graft site.

Upon completion of the surgery, the donor site is dressed with Gelfoam and gauze pads and the recipient area is covered with Telfa. A turban pressure bandage is then applied to the entire scalp. No sutures are needed on the donor site since the donor defects shrink to approximately 1.5 mm. upon healing and do not present a bleeding problem if properly dressed postoperatively.

Generally about 50 grafts are performed at one session. The operative time in experienced hands is about 1½ hours. Establishment of the frontal hairline is exacting and tedious and may take a little more time. A well-trained assistant is essential. The patient is discharged and given appropriate pain medicine. He is also given a three-day course of prednisone to minimize swelling and instructed not to engage in any exertion or drinking over the next 48 hours. The patient returns the next morning (about 12 to 16 hours after the procedure) and his bandage is removed. If he has enough hair to cover the recipient site easily, no observer would ever suspect that surgery had been performed. Over the next two weeks a small scab forms on each graft, and the patient returns to the physician. The scabs are removed and the postoperative sites are examined for any abnormalities. The newly transplanted hairs go into "shock" and are shed in another two to four weeks. Later, in about three months, new hair begins to grow and continues to grow at the normal rate of ½ inch per month. The hair which grows from the graft has all the properties of the area from which it was taken (donor site). Since in the most advanced cases of baldness, a "horseshoe" fringe remains forever, so does the hair in the graft taken from this fringe.

After three months when the transplanted hair has begun to grow, the patient returns for "fill-ins." This is essential if a totally natural look is to be achieved. Unfortunately, some patients are so enthusiastic about their "new" hair that they become satisfied with what we would consider an incomplete result. Fill-ins are placed between existing grafts. The spacing at the time of initial surgery allows for placement of randomized 2, 2½, 3, and 3½ mm. fill-ins at a later date. Spacing must be allowed during the initial coverage sessions. If not, ischemia results and the circulation to the recipient site will be compromised, resulting in poor "takes" and an increased incidence of complications.

Not infrequently, hair loss will continue after transplants have been performed. However, patients will lose their hair at different rates. If the hair loss is a progressive type, the initial planning should include donor reserve considerations for future fill-ins. If the hair loss is extensive, then the predominate number of grafts should be placed in the front and a natural thinning occiput should be allowed to remain.

Many patients wait until their baldness is advanced before they consider transplants. If the procedure is done early, the existing hair will camouflage the operative site. Some patients have had hair transplants over a period of six years, in essence keeping up with their progressive hair loss. They have the same hairline and coverage which they had six years ago, and their friends never suspect that they are having the procedure performed. If the patient is completely bald, a toupe or hairpiece may be worn during the procedure to camouflage the recipient site. This does not interfere with hair growth in the grafts.

In review, hair transplantation is an excellent cosmetic procedure if performed with care and attention to detail. It is indeed unfortunate that preventable "unsatisfactory" results represent a large portion of what the medical and lay community regard as standards.

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Let There Be Light

Joel M. Wilentz, M.D. and Richard S. Greene, M.D.

Understanding of the diverse effects of sunlight on skin is essential in the daily practice of dermatology. It is a requisite both for correct diagnosis of disease and in the treatment of patients. Whether one is dealing with common sunburn, degenerative changes in the skin, dermal neoplasms or dermatoses confined to exposed surfaces, it is necessary to delve deeply into the wealth of accumulated knowledge concerning so-called "photo-dermatology." In the present paper we shall outline for the reader some of the new and more exact principles of classification as used both in diagnosis and in comprehending the mechanisms of action.

Electromagnetic radiation occurs in many forms; the most familiar of these is visible light. The full spectrum from short to long wave-lengths includes: high energy x-rays, ultraviolet rays (10-400 nm)*, visible light (400-700 nm) infrared rays, micro waves, and radio waves. We shall restrict the present discussion to ultraviolet and visible light.

The ultimate source of nearly all energy on earth is the sun. The importance of a small number of cosmic rays which bombard the earth from outer space is unknown and probably unimportant biologically. About 50% of the output of the sun is in the form of visible light; 40% occurs as infrared (non-visible heat) rays; 10% is in the form of ultraviolet light. While the amount and spectrum of solar energy reaching the outer atmosphere of earth is constant, that which reaches the earth's surface (and therefore our patients) varies with such factors as time of day, season of year and quantity of ozone in the atmosphere. The vital importance of the ozone layer in minimizing our exposure to ultraviolet radiation cannot be overstressed. While ozone, if concentrated into a single layer at atmospheric pressures would scarcely measure 3 nm in thickness, this small amount of gas is singularly responsible for absorbing ultraviolet energy and protecting us from its damaging effect. This layer, in fact, absorbs all wave-lengths shorter than 290 nm. Indeed, the ozone itself is generated by the transfer of short ultraviolet (185 nm) energy to oxygen.

The Specter of Ozone Depletion. — The release of fluro-chlorinated hydrocarbon propellants in aerosol dispensers or so-called "spray cans" throughout the world has engendered great concern over possible depletion of the ozone layer. The propellants apparently do not break down in water or earth but diffuse into the atmosphere where they liberate free chlorine and other halogens capable of catalyzine ozone depletion at some 9-16 miles above sea level. The greater the depletion, the greater will be man's exposure to ultraviolet radiation and hence the risk of degenerative skin disorders ranging from sunburn to cancer. The time may therefore soon be at hand when **homo sapiens** will have to decide between the pleasure of personal grooming conveniences (hair sprays, deodorants, etc.) and the hazard of ozone depletion.

Sunburn

Sunburn is by all odds the most common photo-related skin disorder in Florida. Basically it represents a reaction between skin and ultraviolet light in the range 290-300 nm. Although shorter rays, those in the neighborhood of 260 nm are capable of inducing the most intense erythema, man is protected, as pointed out above, by the filtering effect of the ozone layer which practically allows no rays shorter than 295 nm to reach the surface of the earth. The "angle of zenith" is a term used to designate the angle at which light passes to earth and thus through the ozone layer (Figure 1). When light reaches the ozone layer at a right angle, i.e., angle of zenith is 90° the amount of ozone traversed is minimal; at other hours, that is, before or after noonday, the distance to be traversed in passing through the layer is greater. The result is more filtration and less ultraviolet exposure. These statements agree with everyday experience, i.e., burning is most intense at mid-day.

Tanning

Tanning of the skin is brought about by a range of light rays that are, for the most part, slightly longer (320-400 nm or even greater) than those responsible for severe burning. Thus, we can see that the ideal sunscreen or suntan lotion or cream is one that creates a barrier to rays shorter than 320 nm (thus removing burning rays) and allows

*nm = nanometer = 1 millimicron (Mn) = 10 Angstroms (Å).

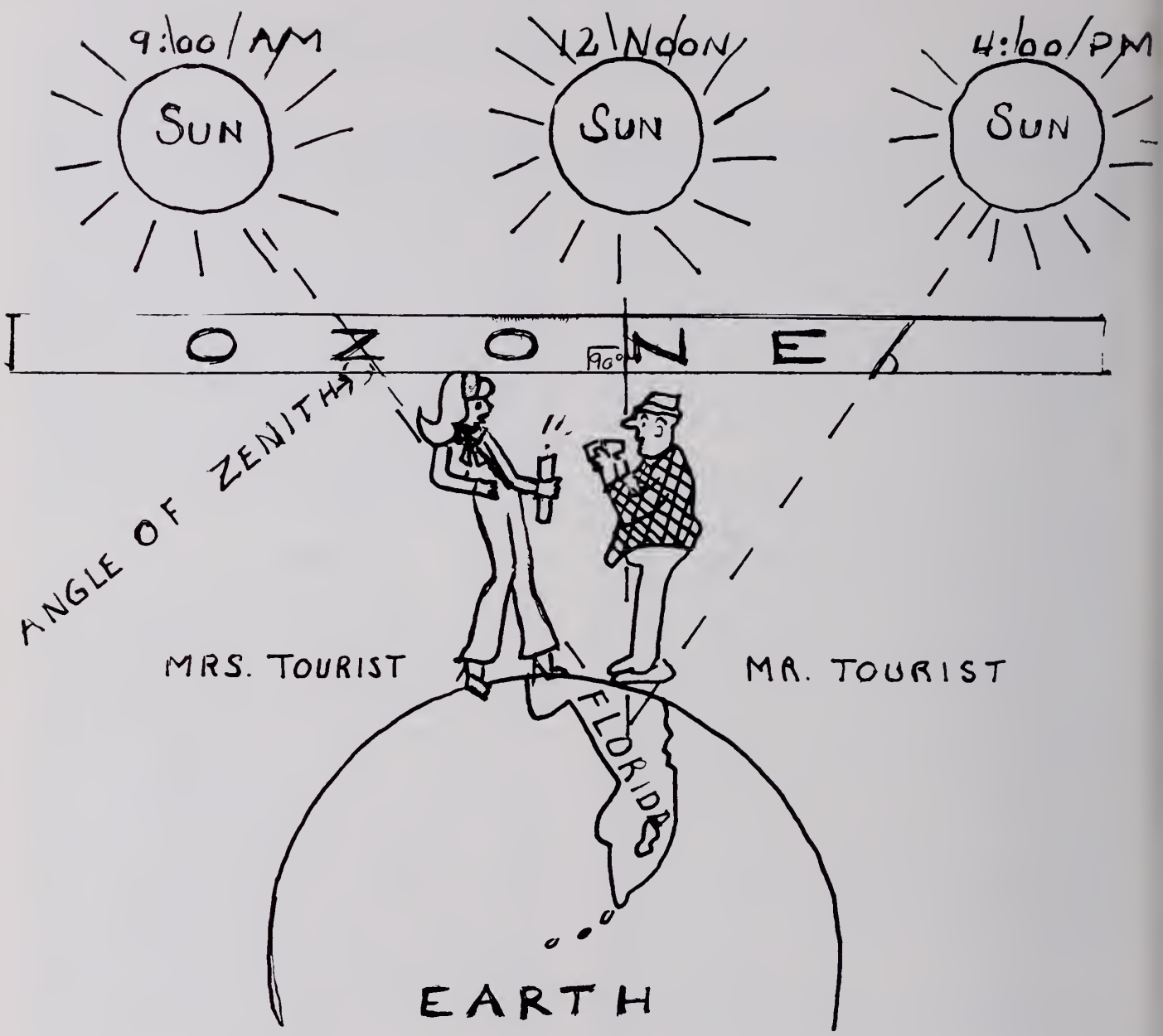


Figure 1

the longer tanning rays to act on the epidermis. Many such preparations are on the market. They are all more or less effective if conscientiously applied.

A further understanding of the relation between skin reactivity and wave-length of light may be had by pointing out that in certain diseased states, the relationship is altered. A case in point is the condition spoken of as "polymorphous light eruption." Here there is evidence of an idiopathic sensitivity to light; in some cases the dermal eruption can be elicited by rays even as long as 480 nm, that is, well within the range of visible blue light. For this condition an effective blocking agent is B-carotene, an orange pigment closely related to vitamin A and responsible for the color of carrots. This pigment absorbs light over the range 360-600 nm.

Selected Mechanisms of Action

Although to a certain extent all normal individuals are sensitive to doses of light energy which exceed their personal normal or developed tolerance, the term photosensitivity is customarily reserved for an abnormal state in which excessive sensitivity to light energy is brought about either by an iatrogenically administered drug or by a metabolically released abnormal compound. It is helpful to regard photosensitivity as being made up of two quite distinct components, i.e., phototoxicity and photoallergy. Phototoxicity is characterized by the following: (1) cell damage occurs on **first** exposure; (2) a period of sensitization is not necessary; (3) there is no chemical alteration of the photosensitizers; (4) a **sunburn type** of reaction is elicited; and (5) within reason, all people receiving a great enough amount of the offending substance will react. It is neither an allergic nor an immunologic response. An example of a phototoxic reaction would be the severe blistering that sometimes ensues in patients with vitiligo or psoriasis who are being treated concomitantly with methoxypsoralin and ultraviolet light.

In contrast, photoallergy refers to a process in which an eruption is characterized by the following: (1) there is no reaction with first exposure; (2) eliciting a reaction demands an incubation period (presumably to build up antibodies); (3) the offending substance is altered chemically; (4) the morphological response expresses itself in varied clinical forms; (5) the unusual reaction may occasionally be accompanied by a flare at distant, previously involved, sites. It represents an immunologic response. A good example of photoallergy is an untoward reaction to one of the "deodorant" (antibacterial) soaps.

Photosensitizer + Energy Absorption	
Phototoxic path	Photoallergic path
Unaltered excitation	New compound formation
Energy transfer	Haptene-protein combination
Free radical and heat formation	Immunocompent cell formation
Nuclear, cytoplasmic and/or cell membrane alteration	Antigen-antibody reaction
Cell Damage	

Clinically, both of the above reactions tend to involve the face, dorsa of the hands, outer aspect of the arms, and the cervix (V) of the neck, i.e., the areas exposed to the sun. Most of the reactions tend to be brief and disappear within one to two weeks after removal of the responsible agent or of the light exposure. Occasionally, however, there are "persistent light reactions" in which evidence of photosensitivity continues for months after known exposure to the drug has ceased.

DNA Repair Failure. — A mechanism of action first discussed by J. C. Cleaver in the late 1960's represents a breakthrough in the understanding of skin cancer and its relation to sunlight. There is a light sensitive disease called xeroderma pigmentosa in which those afflicted tend to have frequent skin cancers. Study of these patients disclosed the following: ultraviolet light damages deoxyribonuclease acid (DNA) principally by creating bonds between adjacent thymine bases on DNA strands (thymine dimers). Normal human cells have the capacity to recognize, excise and repair the damaged DNA; this process is called "patching." Patients with xeroderma pigmentosum exhibit a deficiency of the patching process and the cells carrying the ultraviolet-damaged DNA may either become malignant directly or be more easily invaded by a virus, and thus indirectly become malignant. Fibroblasts from such patients are being studied in order that solar carcinogenesis may be better understood.

Summary

In this brief essay we have made no attempt to list photosensitizing diseases, drugs or topical preparations. Such lists are abundantly available in text books of dermatology and medicine. Rather we have wished to describe the characteristics of the light that reaches our skin, its range of wave-lengths and the interrelation of these wave-lengths with certain disease states. in discussing phototoxicity and photoallergy, we hope to have planted in your minds the seeds of dermatologic thinking. Finally, we have referred to studies of DNA "patching" and expressed the hope that such studies will in the future provide a sound basis for understanding photocarcinogenesis and possibly of other cancer states.

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Pigmentary Changes In Skin Diseases

John H. Hicks, M.D.

Pigmentary change in the skin usually refers either to the loss of melanin pigment or an increased concentration of pigment-containing cells. This is not to say that there are not other pigmentary changes. Deposits of iron (hemosiderosis), carotene (carotenemia), silver (argyria), or bile pigments (jaundice) at times are seen but these are the exception rather than the usual.

The most common types of hyperpigmentation are: (1) melasma (chloasma); (2) new growths such as lentigo, seborrheic keratoses, actinic keratoses, nevi and melanoma; (3) fungus infection such as tinea versicolor or tinea nigra palmaris, and (4) postinflammatory hyperpigmentation.

Melasma

This is a disorder formerly called chloasma which became much more common with the advent of the contraceptive pill. It had been noted before that women would develop the "mask of pregnancy," which usually faded after delivery. However, with the use of anovulatory drugs, many additional cases were noted. In addition to hormonal causes, certain cosmetics are thought to produce the same type of hyperpigmentation of the face. Men are also affected.

Avoidance of the sun is important in treating this disorder, and some success has been obtained with the use of monobenzyl ether of hydroquinone, known as Benoquin. Recent studies show that combinations of retinoic acid-steroid-hydroquinone topically show great promise in effecting a more rapid change. Continued applications are necessary. Dermabrasion for this disorder is not recommended.

Lentigo, Nevi, Seborrheic Keratoses, Actinic Keratoses, Melanoma

There are different types of lentigo but the more common ones for which patients will consult a physician are the "old age spots" on the face, hands and arms. These apparently are precipitated to some extent by sunlight and some are thought be a flat form of seborrheic keratosis. Some will thicken with time. Treatment is time-consuming but if one is tedious in applying trichloracetic acid in the proper strength (20% to 88% concentration) good results can be achieved with minimal scarring. Liquid nitrogen has been used but has the danger of producing hypopigmentation.

Nevi vary from dark brown to having no pigment present and may be raised or flat. The same can be said for melanoma. The size of the nevus may vary widely as some bathing trunk varieties are quite large. It was originally thought that these large, hairy nevi were benign but in recent years many cases have been reported which developed malignant change. Where possible these lesions should be excised. Seborrheic keratoses have a rough surface, are seen past mid-age and may be treated by electrodesiccation or liquid nitrogen.

Sun-related precanceroses, actinic keratoses, around the face, dorsal forearms and hands may be hyperpigmented and may be mistaken for new growths more commonly thought to contain pigment. Many of these brown lesions will disappear after two weeks of treatment with 5-fluorouracil topically.

Fungus Infections Such as Tinea Versicolor

The most common fungus disease producing hyperpigmentation is tinea versicolor. This is a very superficial fungus infection seen primarily from the waist up which sometimes produces hypopigmentation as well. This fungus organism is not difficult to kill yet the disease is difficult to eradicate. The

chronicity of the problem is related to the very widespread involvement common to many patients. Unless all spores and mycelia are killed, the condition will eventually recur. Treatment is with acrisorcin (Akrinol), selenium sulfide (Selsun), or sodium thiosulfate (Tinver).

Another fungus infection which is dark in color is tinea nigra palmaris. This is a localized lesion which is sometimes mistaken for flat nevi or melanoma and is readily curable with most antifungals (Micatin, Tinactin). It is commonly seen in the palm of the hand or botton of the foot.

Postinflammatory Hyperpigmentation

This is a problem often seen in individuals with a deeply pigmented skin. It usually follows some injury to the skin such as a burn or chronic skin disease. Acne excoriee and neurotic excoriations often precipitate this type of darkening. Postinflammatory hyperpigmentation is usually temporary and will fade in time. Treatment is with topical corticosteroids which tend to hasten the disappearance of inflammatory disease. A vigorous effort is needed in treating the primary cause.

Hypopigmentation

Skin diseases in which there is a loss of pigment are cosmetically serious to many people and may be temporary or permanent. An attempt to determine the diagnosis must be made, as some respond well to treatment.

The most common white problems of the skin are: (1) Vitiligo, (2) Tinea versicolor, (3) Pityriasis alba, and (4) Postoperative hypopigmentation.

Vitiligo

Perhaps the most disturbing example of hypopigmentation is the disease vitiligo. In this disorder there is a cessation of melanin production, yet the melanocytes are still alive. The etiology is unkown and in dark-skinned individuals it is a profound cosmetic problem. Sometimes the loss of pigment becomes total. Treatment is generally unsatisfactory, though in some cases repigmentation can be achieved with the systemic administration of Oxsoralen in combination with sunlight. Special care to avoid burning is needed if this treatment is used. New artificial light sources offer added hope. Other reports of success with ACTH and topical steroids have been claimed. In general the disease is chronic.

Tinea Versicolor

This disorder produces circular white spots of small diameter on the back, arms, and upper trunk as well as the dark spots previously described. It is seen more commonly in the summer months in teenagers and young adults. The spots fail to tan. Clusters of spores and short mycella are readily seen on KOH examination and a cure with acrisorcin (Akrinol) can be achieved within a few weeks. The patient should be warned that a return of melanin pigment is slow and thereby not to become discouraged in treating this disorder.

Pityriasis Alba

This is a common disorder in tropical areas where individuals strive zealously to achieve a beautiful tan. It is said to be a component of atopic dermatitis. Many physicians mistake it for a fungus infection. The hypopigmented areas are noted primarily on the face, arms and shoulders and are especially prominent in dark-skinned individuals. Often, the loss of pigment occurs several months following a suntan. The spots may be macular without any obvious change in the epidermis or there may be scaling or, sometimes, frank exzematization. The diameter of the lesion is larger than that of tinea versicolor and the border is indistinct. Treatment is usually successful using topical steroids in an ointment base and avoidance of excessive sun exposure. Sunscreens are helpful.

Postoperative Hypopigmentation

This is a whitening of the skin due to destruction of melanocytes following the use of electrocautery or liquid nitrogen. It is localized to the area in which treatment has been performed, but oftentimes is cosmetically unacceptable. All patients should be warned prior to surgery that this can happen. It is also seen following burns and other injuries such as radiodermatitis.

There are other rare causes of hypopigmentation such as pinta, occupational leukoderma, and albinism, but these are rarely encountered. In those cases where a cure is not possible, camouflaging with cosmetics is an art that only practice and study can improve. Patients are especially grateful for any treatment or cosmetic advice.

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Problems in Pigmentation

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Pigment alteration is so evident that even seemingly subtle changes may cause patients to consult the physician. Many alterations are solely cosmetic, but some signify processes extending beyond the integument. The jaundice of the hepatitic and the pallor of the anemic are well known to all practitioners. Disorders of melanin pigmentation, however, are commonly considered solely within the purview of the dermatologist. These conditions are important not only in themselves, but also because the genetic, biochemical and immunologic aspects of their pathophysiology have broad implications. A discussion of selected pigment abnormalities will further emphasize the scope of dermatology.

Melanin is synthesized in melanocytes, which are widely distributed in the body but markedly concentrated in the retina, leptomeninges, hair follicles, and the basal layer of the epidermis. Melanin in skin is packaged in melanosomes, membrane-limited, subcellular structures produced by melanocytes. Melanosomes are introduced into epidermal cells by the dendrites of the melanocytes. Each dendritic melanocyte and the numerous keratinocytes into which it injects melanosomes is referred to as a functioning epidermal-melanin unit.[1]

All races have the same average number of melanocytes. Differences in pigmentation stem from both the quantities of melanin synthesized and the spatial arrangement of the melanosomes in keratinocytes. For example, groups of small melanosomes are aggregated in membrane-limited organelles in caucasoid keratinocytes, while negroid keratinocytes contain larger single melanosomes.[2]

Although the biochemistry of melanin is still incompletely understood, much progress has been made in recent years. The amino acid tyrosine is progressively oxidized, then polymerized, and finally linked to protein, forming the complex substance, "melanin." The enzyme tyrosinase, present in melanocytes, plays a key role in melanin biosynthesis and is detected histochemically by incubation with dihydroxyphenylalanine—the so-called DOPA reaction.

Pigment abnormalities could logically be a consequence of derangements occurring in any step of the complex series of events in melanin synthesis and distribution. In the following review the pathogenesis of various pigment disorders will be discussed in relation to such specific derangements where this information is available.

Vitiligo is a common disease occurring in approximately 2% of the population. Worldwide in distribution, it is a significant social problem in areas endemic for leprosy where the depigmentation of vitiligo has been confused in the lay mind with the hypopigmentation of Hansen's disease. Even in this country, the darker-skinned patient with vitiligo may not escape the stigma of being "different."

Lesions of vitiligo are depigmented macules which are often hyperpigmented peripherally. Very rarely present at birth, the process begins in 50% of those affected before age 20.[3]

The lesions are usually symmetric and most commonly involve the mouth, eyes, nose, and perineum (periorificial areas). Areas subjected to repeated trauma, such as the knuckles, the elbows, neck and upper trunk, also seem to be particularly susceptible. In a significant minority of cases, unilateral vitiligo occurs which appears dermatomal, yet does not strictly affect the distribution of single peripheral nerves. The course is unpredictable, but typically there are periods of progression, then quiescence, and, at times, partial remission. Recovery may be heralded by spots of pigment in the vitiliginous areas. Total repigmentation is unusual. Although a rare, early lesion may have an inflammatory border, vitiligo is virtually asymptomatic. The depigmented areas are, of course, particularly susceptible to sunburn.

The etiology of vitiligo is unknown. A family history of the condition is obtainable in at least 30% of patients. Even more intriguing is the association of vitiligo with a number of diseases often suspected

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of having an immunologic pathogenesis. Thus, patients with vitiligo have a higher than expected incidence of pernicious anemia, Addison's disease, hypo- and hyperthyroidism, alopecia areata, and diabetes mellitus.[4,9]

Furthermore, circulating organ specific antibodies to thyroid, gastric and adrenal tissue have been found in vitiligo patients.[5-7]

On the other hand, the vast majority of patients with vitiligo have no associated disease. Histologically, melanocytes are either markedly reduced or totally absent in vitiliginous areas. The concept of an "auto-immune" reaction destroying melanocytes and causing depigmentation is attractive. Further circumstantial support for an immunologic etiology comes from work with halo nevi and malignant melanoma, two other conditions with an increased incidence of coexistent vitiligo.[10-13]

Halo nevi are moles which develop a ring of depigmentation followed often by the disappearance of the nevi themselves. Histologically, a dense lymphocytic infiltrate is present during the early evolution of halo nevi, suggestive of a cell-mediated immunologic event. Copeman et al have reported circulating antibodies to malignant melanoma cell cytoplasm in patients with halo nevi.[11]

These antibodies were not demonstrable in vitiligo patients without halo nevi. Antimelanin antibodies have also been found in vitiligo patients but this work has, thus far, not been confirmed.[14]

As mentioned, malignant melanoma victims also have an increased incidence of vitiligo. According to a recent report, several melanoma patients developed vitiligo which the investigators felt was temporally related to successful BCG immunotherapy for metastatic disease.[15] These same patients developed a uveitis compatible with the Vogt-Koyanagi-Harada syndrome, a condition thought to represent a hypersensitivity reaction to uveal pigment. In another investigation, vitiligo-like areas developed in all chimpanzees immunized with human melanoma cells.[16]

The above seem to represent separate pieces in a complex immunologic jigsaw puzzle—intriguing glimpses at a possible humoral mechanism interspersed with hints of a cell-mediated event. But there is not yet enough information to construct a clear picture. The immunologic case is circumstantial, and the pathogenesis of vitiligo remains unknown.

Lerner has suggested that peripheral nerves release a substance toxic to melanocytes.[3]

Although no such chemical(s) has yet been identified, the occasional segmental distribution of vitiligo seems best explained by a "neurogenic mechanism." Lerner has also hypothesized that the melanocyte produces toxic melanin precursors.[10]

Vitiligo would be the result of an inherited defect in eliminating these toxic melanin precursors. In support of this hypothesis, certain substituted phenols which do depigment skin have chemical configurations similar to melanin precursors.[10]

As no consistently effective treatment is available, many dermatologists do not treat vitiligo, but the persistent physician and the dedicated patient can often achieve a satisfactory response. Psoralens, derived from an Egyptian plant, are the mainstay of treatment.[17] These compounds, taken internally or applied topically, sensitize the skin to the action of long-wave ultraviolet light and may produce repigmentation when used conscientiously over a period of months. Their mechanism of action is unknown. Severe sunburn is possible and the treatment should be given only to the intelligent, cooperative patient and administered by a physician familiar with its use.

Corticosteroid therapy has a theoretic appeal to those believing vitiligo is an immunologic phenomenon. Practically, results obtained with systemic, topical and intradermal steroids have been equivocal.[18-20] A recent report suggests success with a topical alcoholic corticosteroid solution; these results await confirmation.[21] The skillful use of opaque, water-resistant cosmetics, such as Covermark,® is often the most satisfying form of therapy.

In summary, most patients with vitiligo can be helped by the enthusiastic dermatologist. Something can be done for many of the patients who are too often told, "There's nothing we can do."

Piebaldism is a dominantly inherited condition characterized by a white forelock and depigmented areas in a characteristic distribution: anterior trunk, mid-arm to mid-wrist, and mid-thigh to mid-calf. Typically, 1-5 cm islands of normal pigmentation are present in the depigmented areas. Histologically the white forelock is devoid of melanocytes as in vitiligo; yet, melanocytes are present in the other hypopigmented areas but they produce abnormal melanosomes.[22] Clinically, piebaldism can be distinguished from vitiligo by its presence at birth and the characteristic distribution of hypopigmentation, particularly the white forelock.

Albinism, in its most common form, is a recessively inherited condition characterized by lessening, but not complete, absence of pigment in the eye and skin. Melanocytes are present, but there is a func-

tional block in melanin synthesis. Thus, the albino has much lighter skin and hair than would be expected for his racial background. Photophobia, nystagmus and decreased visual acuity are probably related to decreased ocular pigment. The hypopigmented skin is particularly susceptible to actinic damage; sun-induced cutaneous malignancies can occur at an early age.

Tuberous sclerosis is an inherited malady consisting of skin lesions, central nervous system abnormalities such as retardation and seizures, and other defects including cystic kidneys and rhabdomyomata of the heart. The earliest manifestation of tuberous sclerosis are hypopigmented macules present in over 90% of affected infants.[23,24] The macules, usually greater than 1 cm in diameter, are most often situated on the trunk and buttocks. These lesions are much more evident under the Wood's lamp ("black light"). It has been suggested that all infants be examined with a Wood's lamp, as the macules are a sensitive marker to this inherited disease.[23] Melanocytes are present in the hypopigmented areas, but, as in albinism, they are effete. Cutaneous lesions developing later include fibrous papules ("adenoma sebaceum") in the "muzzle" area, cafe-au-lait spots, shagreen patches, and subungual fibromata.

Pigment abnormalities are often manifestations of systemic disorders. Addison's disease is a well-known example, with pigment accentuation in areas exposed to light, flexural areas and sites exposed to trauma as well as the nipples, genitalia and scars. Mucous membrane hyperpigmentation is also quite common. Hyperthyroidism can produce similar patterns although mucous membrane involvement is rare. Patients with scleroderma may have a variety of pigment changes. Addisonian alteration, vitiligo-like changes and focal areas of hypo- and hyperpigmentation ("salt and pepper") may occur—even in areas lacking the "hardened" skin so typical of scleroderma.

Drug-induced pigment changes should always be considered when confronted with color alteration. Chlorpromazine produces bluish-gray hyperpigmentation in a small percentage of patients using the medication in high doses for extended periods of time. Although the exact mechanism is unknown, increased cutaneous melanin has been identified.[25] Busulfan, a cytotoxic agent, causes diffuse pigmentation in 5% to 10% of patients.[25] Chloroquine given for long periods can induce bluish discoloration over the face and neck as well as a more diffuse hyperpigmentation in light exposed areas.[25]

Inflammatory processes involving the epidermis may produce pigment alteration by disrupting orderly melanin synthesis and distribution. Hypo- and hyperpigmentation may be the only "evidence" left at the "scene of the crime," long after the perpetrating inflammation has subsided. The physician-detective should always ask, "What was present before the color changed?"

The selected conditions reviewed hopefully give some insight into the variety of mechanisms producing pigment alteration. Because of his training and orientation, the dermatologist is uniquely qualified to assess pigment disorders. His consultation may synthesize seemingly disparate signs and symptoms—serving to enlighten the referring physician and to improve the care of the patient.

References

1. Fitzpatrick, T. B., and Breathnach, A. S.: Das epidermale melanin-einheit-system, Dermatol. Wochenschr. 147:481, 1963.
2. Szabo, G.; Gerald, A. B.; Pathak, M. A., and Fitzpatrick, T. B.: Racial Differences in Fate of Melanosomes in Human Epidermis, Nature 222:1081, 1969.
3. Lerner, A. B.: Vitiligo, J. Invest. Derm. 32:285, 1959.
4. Addison, T.: Disease of Supra-Renal Capsules, Reprinted in Medical Classics, Vol. 2. Baltimore: Williams and Wilkins Co.
5. Dunlop, D.: 86 Cases of Addison's Disease, Brit. Med. J. 2:887, 1963.
6. Cunliffe, W. J.; Hall, R.; Newell, D. J., and Stevenson, C. J.: Vitiligo, Thyroid Disease and Auto-immunity, Brit. J. Derm. 80:135, 1968.
7. Dawber, R. P. R.: Integumentary Associations of Pernicious Anemia, Brit. J. Derm. 82:221, 1970.
8. Dawber, R. P. R.: Vitiligo in Mature-Onset Diabetes Mellitus, Brit. J. Derm. 80:275, 1968.
9. Lerner, A. B.: Three Unusual Pigmentary Syndromes, Arch. Derm. 83:97, 1961.
10. Lerner, A. B.: On the Etiology of Vitiligo and Gray Hair, Am. J. Med. 51:141. 1971.
11. Copeman, P. W. M.; Lewis, M. G.; Phillips, T. M., and Elliott, P. G.: Immunological Associations of Halo Naevus with Cutaneous Malignant Melanoma, Brit. J. Derm. 88:127, 1973.
12. Frenk, E.: Depigmentations Vitiligineuses chez des Patients Atteints de Melanomes Malins, Dermatologica 139-84, 1969.
13. Karcher, K. H.: Systematisierte Depigmentierung bei Stahlenbehandelten Melanomen, Dermatologica 120:255, 1960.
14. Langhof, H.; Feuerstein, M., and Schabrinski, G.: Melaninantikorperbildung bei Vitiligo, Hautarzt 16:209, 1965.
15. Donaldson R. C.; Canaan, S. A.; McLean, R. B., and Ackerman, L. V.: Uveitis and Vitiligo Associated with BCG Treatment for Malignant Melanoma, Surgery 76:771, 1974.
16. Hornung, M. O., and Krementz, E. T.: Specific Tissue and Tumor Responses of Chimpanzees Following Immunization Against Human Melanoma, Surgery 75:477, 1974.
17. El Mofty, A. M.: Vitiligo and Psoralens, New York, Pergamon Press, 1968.
18. El-Mofty, A. M., and Nada, M. M.: Vitiligo and Its Treatment, Aust. J. Derm. 15:15, 1974.
19. Shelley, W. B.: Consultations in Dermatology, W. B. Saunders, Philadelphia, 1972.
20. Kandil, E.: Treatment of Localized Vitiligo with Intradermal Injections of Triamcinolone Acetonide, Dermatologica 140:195, 1970.
21. Kandil, E.: Treatment of Vitiligo with 0.1% Betamethasone 17-valerate in Isopropyl Alcohol—a Double-blind Trial, Br. J. Derm. 91:457, 1974.
22. Breathnach, A. S.; Fitzpatrick, T. B., and Wyllie, L. M. A.: Electron Microscopy of Melanocytes in Human Piebaldism, J. Invest. Derm. 45:28. 1965.
23. Fitzpatrick, T. B.; Arndt, K. A.; Clark, W. H.; Eisen, A. Z.; Van Scott, E. J., and Vaughan J H.: Dermatology in Internal Medicine, McGraw-Hill, New York, 1971.
24. Gold, A. P., and Freeman, J. M.: Depigmented Nevi: Earliest Sign of Tuberous Sclerosis, Pediatrics. 35:1003, 1965.
25. Rook, A. J.; Wilkinson. D. S., and Ebling, F. J. G.: Textbook of Dermatology, Blackwell Scientific Publications, Oxford, 1972, p. 1266.

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Malignant Melanoma or Harmless Mole?

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Abstract: Malignant melanoma can often be distinguished from nevi on the basis of certain clinical features. Irregular, hazy, asymmetrical margins and variations in color may be significant. Shades of brown combined with black and red are characteristic of melanoma. An adequate biopsy should be done prior to definitive surgical management.

Clinicians in many specialties are asked to evaluate skin lesions. Frequently the patient will ask his physician about a pigmented "growth" which has been present for years. In evaluating the lesion, a diagnostic problem often occurs in differentiating nevi from malignant melanoma. Because of the serious consequences of failure to recognize a melanoma, it is important to make this distinction.

Nevi ("moles") are tumors formed by the proliferation of cells similar to melanocytes. They occur in all races. Nevi are uncommon in infancy and the incidence increases gradually during childhood. In adolescence there may be a rapid increase in number. Nevi may gradually increase in number during adulthood, but in old age their frequency decreases.[1] Most people have at least a few nevi.

Malignant melanoma is a tumor of the skin developing from melanocytes. It has the potential for widespread metastases and can be fatal within a short time. During 1974, in the United States there were an estimated 8,200 new cases of malignant melanoma. In this same year approximately 5,100 people died from malignant melanoma.[2] Light-complexioned people and those with frequent sun exposure are more prone to develop melanoma. The mean age of patients diagnosed is usually between the fourth and the sixth decade.[3] Melanoma is very rare before puberty.

Clinical features of nevi vary. They are usually pigmented and may be light tan, dark brown, or black. Most are less than 1.5 cm in diameter, flat or dome-shaped, the surface smooth or papillomatous, the outline usually round or elliptical.[4] Any area of the cutaneous surface may be involved. Some nevi have dark coarse hairs projecting from the surface. The natural history of nevi is for continued growth during late childhood and adult life. After the age of 60 they frequently diminish in size. In very old people (age 80-90), nevi are greatly reduced in number and size.

Malignant melanoma usually appears asymmetrical in outline. The color varies greatly and may show brown, black, pink, red, or even white areas with no pigmentation. It is significant that several colors are often present within a single lesion (Figure 1).* This is in contrast to the even pigmentation usually seen in nevi. Melanoma may be flat or a raised plaque or nodule. There is usually an area which is coal-black, but close examination will frequently reveal traces of brown or pink in other areas of the lesion. The edges of the tumor are characteristically hazy and difficult to delineate. There may be areas of ulceration and slight bleeding. Clark and his associates[5] have classified malignant melanoma into lentigo-maligna melanoma, superficial spreading melanoma, and nodular melanoma. These distinctions are based on clinical and pathological correlation. However, all malignant melanomas are potentially fatal. The prognosis can be made based on the depth of invasion of the skin at the time of biopsy. In general, the course of malignant melanoma is unpredictable.

The pathology of nevi varies. Nests of uniform nevus cells may be located in the lower epidermis near the junction with the dermis. Or, most of the nevus cells may be located in the dermis. These cells may be cuboidal or elongated, but have an orderly appearance. Malignant melanoma shows a typical anaplastic cells involving the epidermis and dermis (Figure 2).* The size and shape of the melanoma cells vary.[6] There is a disorderly arrangement and often irregular branching strands of pigmented cells extend into the dermis. Melanoma can originate from nevus cells or from an area where no preceding lesion was apparent.

In addition to nevi, melanoma may also be confused with granuloma pyogenicum, actinic keratosis, and traumatized molluscum contagiosum. The differential diagnosis also includes other pigmented lesions such as Bowen's disease, seborrheic keratosis, lentigo, and pigmented basal cell carcinoma.

What should be done when a lesion is suspicious

*See page 82a

of malignant melonoma? Biopsy is indicated. If the lesion is small an excision biopsy is preferable. Lesions greater than 1-2 cm or those on areas where complete excision would be technically difficult may be biopsied by taking a 4-5 mm incisional specimen. When melanoma is suspected, a full skin-thickness biopsy should be done. This will make it possible to determine the level of invasion of the tumor. Radical surgery should not be done before the diagnosis is established by biopsy. Once the diagnosis of malignant melanoma has been made, the patient should be treated surgically. If diagnosed and treated early, the outlook is not hopeless.

References

1. Rook, A.; Wilkinson, D.S.; Ebling, F. J. G.: Textbook of Dermatology, ed. 1, Oxford, England, Blackwell Scientific Publications, 1968, p. 102.
2. Silverberg, E.; Holleb, A. I.: Cancer Statistics, 1974—Worldwide Epidemiology. Cancer 24: 10-11.
3. Clark, W. H.; Mihm, M. C.: Moles and Malignant Melanoma, in Fitzpatrick, T. B., et al (eds): Dermatology in General Medicine. New York, McGraw-Hill Book Co. Inc., 1971, p. 507.
4. Rook, A.; Wilkerson, D. S.; Ebling, F. J. G.: Textbook of Dermatology, ed. 1, Oxford, England, Blackwell Scientific Publications, 1968, p. 104.
5. Mihm, M. C.; Clark, W. H.; From, L.: The Clinical Diagnosis, Classification and Histogenic Concepts of the Early Stages of Cutaneous Malignant Melanomas. New England J. Med. 284: 1078-1082, 1971.
6. Lever, W. F.: Histopathology of the Skin, New York, J. B. Lippincott Co., 1967, p. 721.

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Cancer of the Skin

A Common Medical Problem for the Florida Physician

Henry Menn, M.D.

Abstract: The principles of diagnosis, prognosis and treatment of cancer of the skin, one of the most common dermatological problems encountered by the Florida physician, are outlined. Cure rates can be expected on the order of 95% for primary basal and squamous cell carcinoma. Recurrent skin cancer presents a more difficult therapeutic problem. The Mohs chemosurgery technique, excision guided by microscopic study, is uniquely designed to treat recurrent skin cancer.

Cancer of the skin is the most common malignancy of man. Ironically, its very frequency and the reported success of even simple forms of therapy may lead physicians, and patients, to underestimate its seriousness. The fact that proper treatment effects a cure in some 95% of cases is reason enough for every practicing physician to critically assess the accuracy of his diagnosis and the skill of his treatment.

It is estimated that 118,000 new cases of cancer of the skin are detected in the United States each year.[1] The majority are basal cell and squamous cell carcinomas arising in sun-exposed areas of the head and neck during the fifth or sixth decade of life.[2,3] Fortunately, less than 0.5% of cancers of sun-damaged skin metastasize[4,5] and only 5% recur following treatment by experienced clinicians.[6] The literature concerned with the treatment of basal cell and squamous cell carcinoms supplies a plan of management that can give this high degree of success, providing the methods described are followed closely.

The rate of metastasis is much higher with squamous cell carcinoma arising on mucous membrane of the lips or genitalia and with skin cancer developing in scar tissue. Some of the principles outlined here may not be applicable to their management.

Diagnosis

Usually, a patient directs attention to a new growth or a sore on the skin that has not healed. If there is any doubt about the cause of such a lesion, a biopsy should be performed. Using local anesthesia, one can excise a portion or remove a plug of suspicious tissue with a skin punch biopsy instrument. Direct pressure effects hemostasis, sutures are rarely required, and a simple dressing suffices.

The pathologist's report should be reviewed before treatment. If malignancy is confirmed, the primary objective will be complete destruction and this invariably produces some scarring. Without a histologic examination, cosmetic considerations may sway a physician toward inadequate treatment. Many patients (and insurance companies) will insist on biopsy. A negative laboratory report will reassure the patient. A study of the accuracy of dermatologists in diagnosing 3,010 cases of basal cell carcinoma by inspection alone showed error in one fourth of the cases.[7]

Prognosis

If a physician is reasonably certain on clinical grounds that a skin lesion is cancer, he should so inform the patient, keeping in mind that the patient probably already suspects this. As I inform a patient of my clinical diagnosis, I explain the significance of cancer of the skin and give a prognosis, generally saying something like this:

"My examination indicates that you have a cancer of the skin. I can be certain of this diagnosis only by performing a biopsy so that the tissue can be studied under a microscope. Fortunately, cancer of the skin does not have the serious implications of cancer of internal organs. It rarely spreads in the bloodstream to other organs or shortens life."

"Treatment is curative in better than 90% of all cases. I will recommend the type of treatment to be used after I review the biopsy report. It is only fair to explain that while skin cancer is usually cured, there is a possibility that it may regrow or that another skin cancer may develop. Because of this, we will arrange for follow-up examinations and discuss preventive measures that can be taken to decrease the likelihood of development of another skin cancer."

The discourse will help allay apprehension and go a long way toward establishing the rapport necessary for cooperation in follow-up care.

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The risk of developing a new skin cancer or recurrent skin cancer in patients who had at least one skin cancer is no less than 22% and may approach 50% in the first 18 months following initial treatment. This high rate emphasizes the need for repeated examinations of all patients with a history of skin cancer.[8]

Treatment

The primary objective is complete destruction of the cancer by the initial treatment. Achieving the best possible cosmetic result also is important, but the consequences of obtaining this objective by compromising the primary one may be serious. A recurrence of the cancer will shatter the patient's trust and require more extensive treatment that has less chance for success. In a recent study the cure rate of retreatment of recurrent basal cell carcinoma with ordinary forms of therapy was less than 50%.[9]

The choice of initial therapy is based on clinical and pathologic studies. Tumor size and location are of paramount significance. Careful palpation often gives evidence of "iceberg" extensions that make the overall dimensions of a tumor much greater than surface inspection indicates. Cancers in the nasolabial crease or the inner canthus or on the pinna of the ear are notorious for their deep invasion and consequently higher rate of recurrence.

The histologic findings may influence the choice or extent of therapy. Strandlike tumor cords embedded in dense connective tissue are not easily excised by curettage, and cancers of the skin with glandular differentiation may not be totally radiosensitive. This knowledge is of no avail if one treats the tumor at the time of the biopsy.

Curettage and Electrodesiccation—This is probably the most frequently used method of treating cancer of the skin. A cure rate of 95% can be expected, but one should remember that the reports documenting this success concerned the use of this procedure in previously untreated basal cell and squamous cell carcinomas less than 2 cm. in diameter (less than 1 cm. in the majority of cases).[10]

Unfortunately, many persons, including some physicians, incorrectly refer to this method as "burning out" a skin cancer. Properly performed, curettage is an excision of a skin tumor. With experience, one can "feel" the difference between the soft cancerous growth and the firm, gritty, normal dermis beyond the tumor margins. When the excision is completed, electrodesiccation is used to effect hemostasis and to destroy any viable malignant cells remaining at the margins or in the base of the wound. The would heals by secondary intention and the cosmetic result is remarkably good.

Repeated success with this method should not lead one to use it in cases other than those in which it has been shown to be effective. Tumors larger than 2 cm. or recurrent tumors embedded in dense scar tissue cannot be excised by a curette with the same success.

Surgical Excision—This method of treatment accomplishes the objective quickly and with little discomfort for the patient. The resulting scar is hardly noticeable if the incision is properly made in a facial wrinkle line. The most important advantage of surgical excision is that histologic study of excised tissue allows determination of whether or not the margins are free of tumor.

Noteworthy with respect to histologic examination in these cases is a report involving 66 basal cell carcinomas with extension of the malignancy to the surgical margin.[11] During five years of follow-up, "only" one third of these patients showed clinical evidence of recurrence, and it was concluded that immediate reexcision was therefore unnecessary. For those patients with clinical evidence of recurrence (about one in three), the risks are obvious. Temporizing could allow a tumor known to be incompletely excised to increase in size and invade vital structures. Immediate retreatment seems far more reasonable.

Radiotherapy—A high cure rate and good cosmetic results may be expected with x-ray therapy of facial cancers.[12] Specialized training and precision instrumentation are required. Five to 10 treatment sessions over 10 to 20 days are necessary. The acute phase of radionecrosis subsides in four to six weeks. By reason of the sheer numbers of cutaneous malignancies and the sophistication of the technique, x-ray therapy is less practical than other methods as the usual first line of treatment. When curettage and electrodesiccation may not be adequate or when surgical excision is impractical, the radiotherapist plays an important role in the management of cancer of the skin.

Cryosurgery—During the past ten years, several dermatologists have compiled an impressive record by treating cancers of the skin with liquid nitrogen.[13-15] Destruction of the tumor by freezing is accomplished quickly and with minimal discomfort. It is an outpatient procedure and healing with minimal scarring occurs over two to three weeks. For a patient with multiple early skin cancers, cryosurgery may be the treatment of choice. Dozens of tumors may be destroyed during one session without injection of a local anesthetic. Treatment of the

more aggressive lesions requires special delivery systems for liquid nitrogen and thermocouples to monitor depth of tissue freezing, but those with experience claim success with even advanced basal cell and squamous cell carcinomas.

Chemotherapy—Systemic chemotherapy for skin cancer unfortunately has met with little success. It has not been shown to increase the survival time of patients with locally invasive or metastatic basal cell or squamous cell carcinomas. In fact, some observers advise against the use of chemotherapy on the grounds that the toxic effects may not be justifiable in patients whose disease is so slowly progressive.

Perhaps the greatest hope for future control of cancer of the skin will be topical chemotherapy. The success of 5-fluorouracil in the treatment of actinic keratosis,[16,17] a premalignant skin condition, offers encouragement that an antimetabolite may yet be discovered which can be applied topically to eradicate skin cancer.

Unfortunately 5-fluorouracil has not been consistently effective in destroying skin cancer in my experience, nor has the drug been approved by the FDA for use on lesions other than those judged histologically premalignant.

Mohs Chemosurgery—Some 15 physicians in medical centers across the United States are using chemosurgery, a term introduced by Mohs[18] to denote the use of zinc chloride to accomplish in situ fixation of surface cancer. Use of the chemical is followed by surgical excision of tissue and immediate microscopic examination for tumor extensions. The process is repeated until a tumor-free tissue plane is reached. An obvious advantage is the exact microscopic control of the extent of surgery. Serial excisions and microscopic examinations permit identification and destruction of tumor extensions not apparent to surface inspection. In recurrent skin cancers in particular, discrepancies between gross size and microscopic extent are often considerable. Surgical excision guided by microscopic study, which is essentially what the chemosurgical technique is, has given a much higher cure rate of recurrent skin cancers than any other form of treatment.[19]

Mohs Chemosurgery Case Reports

Case 1.—A 61-year-old man allowed a primary basal cell carcinoma to reach gigantic proportion before seeking medical attention (Fig. 1)*. Following partial bulk tumor excision by curettage, dichloroacetic acid was applied to establish hemostasis (Fig. 2)*, and to facilitate the percutaneous absorption of zinc chloride fixative paste (Fig. 3)*. Several hours later surgical sections were excised (Fig. 4)*, and their exact location was drawn on a wound map (Fig. 5). Frozen sections were cut horizontally from the undersurface of each specimen. Microscopic examination disclosed residual tumor in some areas (Fig. 6) and these sites requiring further chemical fixation and surgical excision were recorded on the wound map. The inferior portion of the tumor was similarly treated and eventually microscopic study of the surgical specimens revealed a tumor-free tissue plane had been reached (Fig. 7)*. Careful attention to daily wound debridement produced an excellent cosmetic result without skin graft surgery (Fig. 8)*. To date the patient has been followed three years and is free of skin cancer.

Case 2.—A 63-year-old woman had biopsy proven basal cell carcinoma recurrent at each end of a surgical scar (Fig. 9)*. Chemosurgical excision and systematic microscopic examination disclosed the extension of tumor beneath the normal appearing central scar area (Fig. 10)*. Healing by secondary intention resulted in a good cosmetic result without the need for reconstructive surgery (Fig. 11)*. Further recurrence has not been detected during a three-year follow-up period.

Case 3.—A 67-year-old man had invasive basal cell carcinoma embedded in an area of chronic radiodermatitis on his chin, and left cheek (Fig. 12)*. Chemosurgery was performed over a period of four days. A total of 47 tissue sections were excised and microscopically examined until a tumor free tissue plane was reached (Fig. 13)*. Anticipation of retraction deformity demanded immediate reconstructive surgical repair of the chemosurgery wounds. Skin flaps rotated from non-x-ray damaged cervical skin produced an excellent cosmetic result (Fig. 14)*. The patient has remained free of recurrent basal cell carcinoma during a three-year postoperative period.

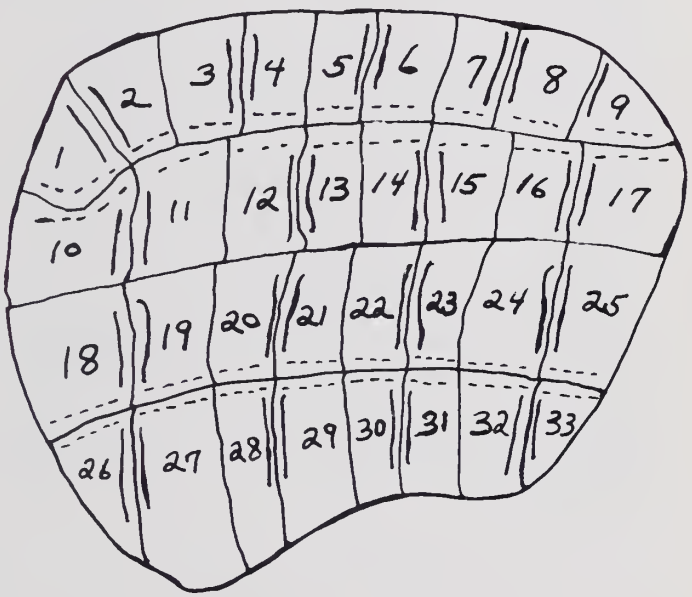


Figure 5

The surgical map is a graphic reproduction of the wound site. Adjacent edges of each specimen are marked with blue (dotted line) and red (solid line) dyes to distinguish superior, inferior, medial and lateral margins. Horizontal frozen sections are cut from the undersurface of each specimen and stained for microscopic examination by the chemosurgeon. In this case 33 sections were examined. Basal cell carcinoma was present in 14 sections. The exact location of residual tumor was recorded on the map and additional chemosurgical chemicals were applied to the corresponding areas of the surgical wound to prepare the site for further surgical excision and microscopic examination. The process is repeated until no further tumor is seen on microscopic examination.

*See page 82a

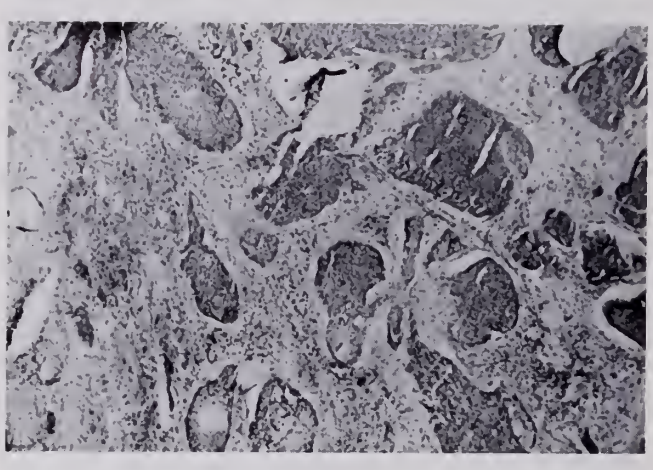


Figure 6

Indications for Mohs Chemosurgery

There are several reasons why chemosurgery is usually reserved for recurrent or unusually aggressive primary skin cancers. Most importantly, the cure rate is no better than conventional therapy for the majority of primary skin cancers. In addition, the procedure requires several days to complete and a histopathology laboratory must be maintained to prepare specimens for the chemosurgeon to examine microscopically. As a result, the cost of the technique is higher than usual and customary dermatology fees for the treatment of skin cancer.

None of these considerations should sway the physician from referring a patient for chemosurgery in an instance where the usually successful forms of treatment have failed to produce a cure. The recurrent skin cancer is a far more serious threat to the patient's well being, and the Mohs chemosurgery technique offers the best opportunity to produce a cure.

Acknowledgments

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Case No. 3—Reconstructive surgery was performed by Walter Garst, M.D., Clinical Assistant Professor of Plastic Surgery, University of Miami School of Medicine.

References

1. Silverberg, E. and Holleb, A. I.: Cancer Statistics 1972, Cancer 22:2-20, 1972.
2. Gellin, G. A.; Kopf, A. W., and Garfinkel, L.: Basal Cell Epithelioma: A Controlled Study of Associated Factors, Arch. Dermat. 91:38-45, 1965.
3. Urbach, F. ed.: Biological Effects of Ultraviolet Radiation, Oxford, England, Pergamon Press, 1969, p. 581.
4. Wermuth, B. M. and Fajardo, L. F.: Metastatic Basal Cell Carcinoma: A Review, Arch. Path. 90:458-462, 1970.
5. Epstein, E.; Epstein, N. N., and Bragg, K., et al: Metastases From Squamous Cell Carcinomas of Skin, Arch. Dermat. 97:245-251, 1968.
6. Kopf, A. W.: Management of Skin Cancer: A Symposium, New York State J. Med. 68:863-911, 1968.
7. Lightstone, A. C.; Kopf, A. W., and Garfinkel, L.: Diagnostic Accuracy—A New Approach to Its Evaluation: Results in Basal Cell Epitheliomas, Arch. Dermat. 91:497-502, 1965.
8. Bergstresser, P. R. and Halprin, K. M.: Multiple Sequential Skin Cancers, Arch. Dermat. 111:995-996, 1975.
9. Menn, H., et al: Recurrent Basal Cell Epithelioma: Study of 100 Cases of Recurrent, Retreated Basal Cell Epitheliomas, Arch. Dermat. 103:628-631, 1971.
10. Knox, J. M.; Freeman, R. G., and Heaton, C. L.: Curettage and Electrodesiccation In Treatment of Skin Cancer, South. M. J. 55:1212, 1962.
11. Gooding, C. A.; White, G., and Yatsuhasi, M.: Significance of Marginal Extension in Excised Basal-Cell Carcinoma, New England J. Med. 273:923-924, 1965.
12. Bart, R. S., et al: X-ray Therapy of Skin Cancer: Evaluation of "Standardized" Method for Treating Basal Cell Epitheliomas. Sixth National Cancer Conference Proceedings. Philadelphia, J. B. Lippincott Company, 1970 p. 559.
13. Zacarian, S. A.: Cryosurgery of Skin Cancer and Cryogenic Techniques in Dermatology, Springfield, Ill., Charles C. Thomas, 1969.
14. Torre, D.: Cutaneous Cryosurgery, J. Cryosurg. 1:202, 1968.
15. Graham, G. C.: Cryosurgery of Skin Tumors, North Carolina M. J. 32:81-87, 1971.
16. Dillaha, C. J.; Jansen, G. T., and Honeycutt, W. M., et al: Selective Cytotoxic Effect of Topical 5-fluorouracil, Arch. Dermat. 88:247, 1963.
17. ————: Further Studies with Topical 5-fluorouracil, Arch. Dermat. 92:410, 1965.
18. Mohs, F.: Chemosurgery in Cancer, Gangrene and Infections, Springfield, Ill., Charles C. Thomas, 1956.
19. Tromovitch, T. A.; Beirne, G., and Beirne, C.: Mohs Technique (Cancer Chemosurgery): Treatment of Recurrent Cutaneous Carcinomas, Cancer 19:867-868, 1966.

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Surgical Repair of Operative Defects After Skin Cancer Excision

Terrence A. Cronin, M.D.

Simple Repair

A number of modalities may be used in the treatment of primary malignancies of the skin. In many instances excision by scalpel is the treatment of choice, particularly for those of the face. The result depends upon the surgeon's technique especially in closing the defect and the patient's natural healing factors.

The simplest excision is creation of the defect and the sharp dissecting away of diseased tissue without closure. This can be performed with minimal risk to the patient and is useful in those whose general physical condition is poor. In my experience, defects up to six inches in diameter have been left open to heal by secondary intention and have done so without complications. The result is acceptable for the patient in poor general health. This modality, however, is not recommended except in most unusual or emergency circumstances for those inexperienced in removal of skin lesions.

Wounds that heal by primary intention, in other words, epithelium to epithelium, will heal with a smaller, less noticeable scar. Excision reveals that most wounds are circular, especially if the line follows the general outline of the tumor which also tends to be circular. By excising a cone of normal tissue on both ends of the circle, an ellipse is formed and this strictly speaking lenticular excision can then be closed as a straight line. In many areas it is difficult to close an ellipse without first undermining the surrounding skin. This is easily accomplished by separating the skin at the dermal subcutaneous junction either by scalpel or special undermining scissors.

Different methods of closure then are possible including inverted buried subcuticular sutures, running subcuticular sutures, and interrupted sutures with or without the use of vertical or horizontal mattress sutures. Healing time generally is one week or less on the face. Over a period of a year the linear scar fades to become a hardly noticeable white line. In some instances the line may be impossible to locate. This should not be promised to the patient, however, due to the individual variations in the healing process.

Use of Local Flaps in Skin Surgery

Local flaps have their greatest application in repair of large defects after excision of skin malignancies. They are also quite useful in areas where it is necessary to change the geometry of the wound, where an elliptical excision would destroy vital structures such as the nose. The properly designed flap takes advantage of the inherent elasticity of the skin, making it possible to close primarily most defects.

Several flaps are discussed which have the most application in dermatological surgery.

The first is the simple or single advancement flap (Fig. 1, Case 1). First note that a properly designed and closed ellipse is a flap since the wound edges are undermined and the overlying skin is moved to effect a primary closure.

In areas such as the corner of the mouth, angle of the nose and the eyebrow, the ellipse might destroy the vital anatomy of the face, actually be impossible to construct or too large to close. A vital structure such as the base of the nose might be at a point of the excision. In this instance a single advancement flap is quite effective. The wound is designed in such a way as to form approximately ½ to ⅔ of a convex lens or a triangular defect. An extension incision which can go in either direction is made at the base. A small Burow's triangle may or may not be necessary to take up the redundant tissue.

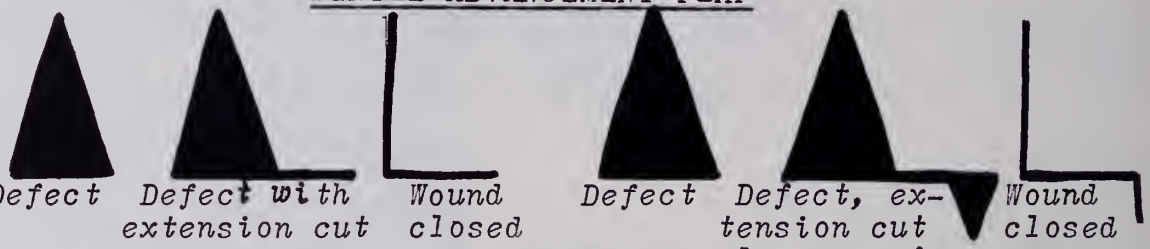
The flap then is picked up from underlying tissue and dissected free. The remaining wound edges are also deeply undermined. This accomplishes two purposes: It breaks up the geometry of the wound to avoid vital structures, and increases the ability for edges of the wound to be stretched from 40% to 60%. When healed, this leaves a scar in the shape of an "L" or "Z".

See Page 82a for color illustrations

THE FOLLOWING SIMPLE GEOMETRIC ILLUSTRATIONS ARE FIVE OF THE MOST POPULAR AND USEFUL PLASTIC TISSUE REARRANGEMENTS TO CLOSE WITHOUT TENSION A GAPING EXCISIONAL WOUND FOR CA.

SINGLE ADVANCEMENT FLAP

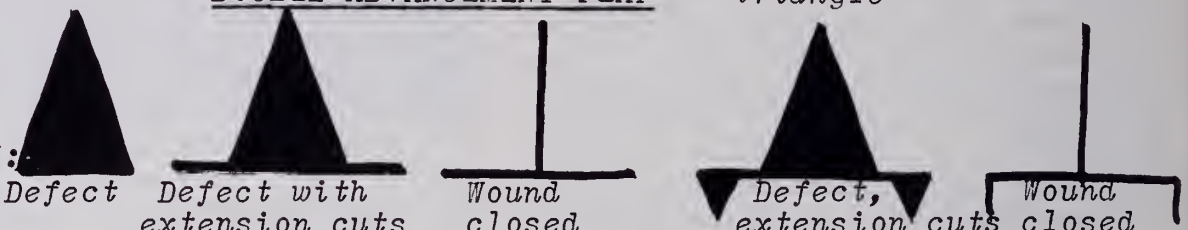
Figure I:



Defect — *Defect with extension cut* — *Wound closed* — *Defect* — *Defect, extension cut plus Burow's triangle* — *Wound closed*

DOUBLE ADVANCEMENT FLAP

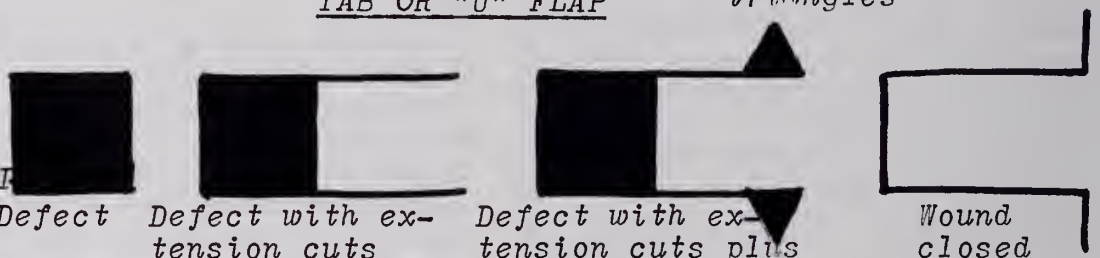
Figure II:



Defect — *Defect with extension cuts* — *Wound closed* — *Defect, extension cuts plus Burow's triangles* — *Wound closed*

TAB OR "U" FLAP

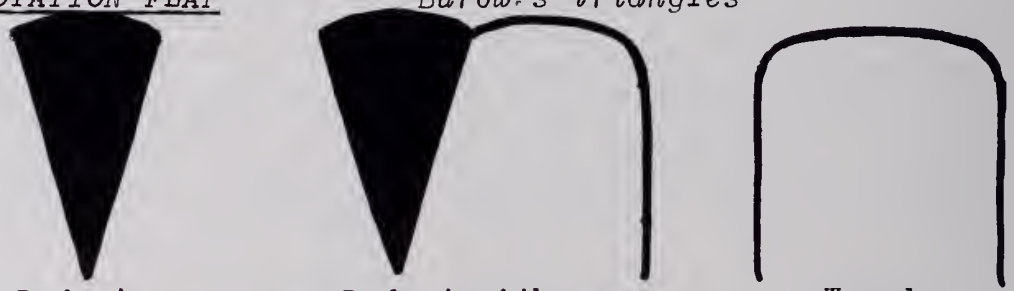
Figure III:



Defect — *Defect with extension cuts* — *Defect with extension cuts plus Burow's triangles* — *Wound closed*

ROTATION FLAP

Figure IV:



Defect — *Defect with extension cut* — *Wound closed*

TRANSPOSITION FLAP

Figure V:



Defect — *Defect with extension cut* — *Wound closed*

The second type is the double advancement flap, also called the "T" flap, which is of value where the single advancement flap would not give enough tissue to make a closure that would not be inordinately tight. Essentially it is the same as two single flaps placed next to each other. Done without Burow's triangle, it gives a T-shaped scar. When Burow's triangles are present, it will appear as a pitchfork (Fig. 2, Case 2).

The third flap is called the "U" or tab advancement flap, valuable for lesions of the tip and sides of the nose. The defect is cut essentially as a square (Fig. 3, Case 3). Two extension incisions are made in the direction of choice and the tab-shaped flap is picked up from underlying tissue and dissected free. If necessary two paralleled Burow's triangles are put in at the end of the incisions. The flap then is closed into the previously undermined defect in the shape of a "U" which may or may not have little points on the end, depending on the presence of the Burow's triangles.

The fourth is the rotation flap of great value on the nose (Fig. 4). Again the original defect is in the shape of a triangle or cone, an excision is made from the base of the triangle and extended until a circular flap is cut from the tissue. Then the flap is deeply undermined. The wound edges are also undermined and closed in the shape of a "C" or partially closed circle.

The last flap is the transposition flap. There are several variations (Fig. 5, Case 4). The defect is cut and a flap of essentially the same size and shape as the defect is cut on either side of it. The flap is then undermined and fitted into the primary defect. The secondary defect is closed primarily or perhaps closed with the help of a secondary simple flap.

With the proper use of these simple flaps, almost all defects resulting from adequate excision of skin carcinoma can be closed. Particularly is this true for carcinoma of the face. Skin flaps are an important part of the dermatologist's armamentarium and many of these specialists are proficient in their usage.

See Page 82a for color illustrations

Bibliography

Constantine, V. S.; Mason, B. H., and Self, S. J.: Pinch Grafts for Chronic Stasis Ulcers, Cutis 5:1367, 1969.
Cronin, T. A.: Wound Closure, in Dermatology in Practice, Vol. 8, No. 5, Oct. 1975.
Epstein, E.: Skin Surgery, 3rd ed., Charles C. Thomas, Springfield, Ill., 1970.
Grabb, W. C., and Smith, J. W.: Plastic Surgery, 1st ed., Little, Brown & Co., Boston, 1968.
Konz B.: Use of Skin Flaps in Dermatologic Surgery of Face, J. Derm. Surg., Vol. 1, No. 3, Oct. 1975.
McGregor, I. A.: Fundamental Techniques of Plastic Surgery, 3rd ed., Williams and Wilkins, Baltimore, 1965.
Rob, C.; Smith, R., and Battle, R. J. V.: Operative Surgery, Plastic Surgery, 2nd ed., Butterworths, Reading, Mass.
Smith, J. D.; Holder, W. R., and Smith, E. B.: Pinch Grafts for Cutaneous Ulcers, South. M. J. 64:1166, 1971.
Stark, R. B.: Plastic Surgery, Hoeber Medical Division, Harper and Rowe, New York, 1962.

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Health and Nutrition Examination Survey In Dade County

The U.S. Public Health Service will begin a Health and Nutrition Examination Survey in Dade County on February 9.

Household interviews will be conducted to identify about 492 individuals ranging in age from 6 months to 74 years who will be examined from February 20 through March 25, 1976, in the Survey's mobile examination center.

The Dade County project will focus on dietary intake, laboratory tests, body measurements and clinical assessments. Data also will be compiled on the prevalence of the following conditions in certain age groups: diabetes, kidney disease, heart disease, liver disease, hypertension, allergy, speech defects and hearing problems, osteoarthritis, disc degeneration in the cervical and lumbar spines, and otitis media.

Information may be obtained from Mr. Charles Gallese, National Center for Health Statistics, Health Resources Administration, U.S. Public Health Service, Rockville, Md. 20852. Telephone (301) 443-1626.

Current Status of Syphilis and Other Venereal Diseases

Milton S. Ross, M.D.

The newspaper headline declares "Florida's V.D. Rate Jumps 50%, Leads Nation," and goes on to say, "The state's incidence rate of 36.4 per 100,000 is substantially higher than South Carolina's 25.5 cases per 100,000 population." Nationally the rate is 2%. Florida ranks high in the incidence of gonorrhea as well, but among the states it is fourth with a rate increase of 17% over 1973. Does this represent a lack of effort or concern on the part of health authorities? Not at all. Traditional methods of epidemiology, contact tracing, interviewing and epidemiological treatment have been pursued as intensively as personnel and money permit.

New and sophisticated techniques have been developed. A huge gonorrhea screening program aimed especially at asymptomatic females has functioned for the past three years to uncover a suspected reservoir of undetected infection and many such patients have been found. But the rates have continued to go up.

As compared to private clinics, health department VD clinics uncovered a much larger number of actual infections among asymptomatic females who came in for routine checks. This screening effort has been partly responsible for the increase in reported cases, but the rapidly rising rate of gonorrhea cannot be entirely accounted for in this manner. As has been pointed out, the rate of increase is diminishing. Nevertheless, there are an estimated two million cases of gonorrhea in the U.S., with 900,000 new cases being reported in 1974. Gonorrhea continues to have the highest incidence of any reportable infectious disease (Fig. 1).

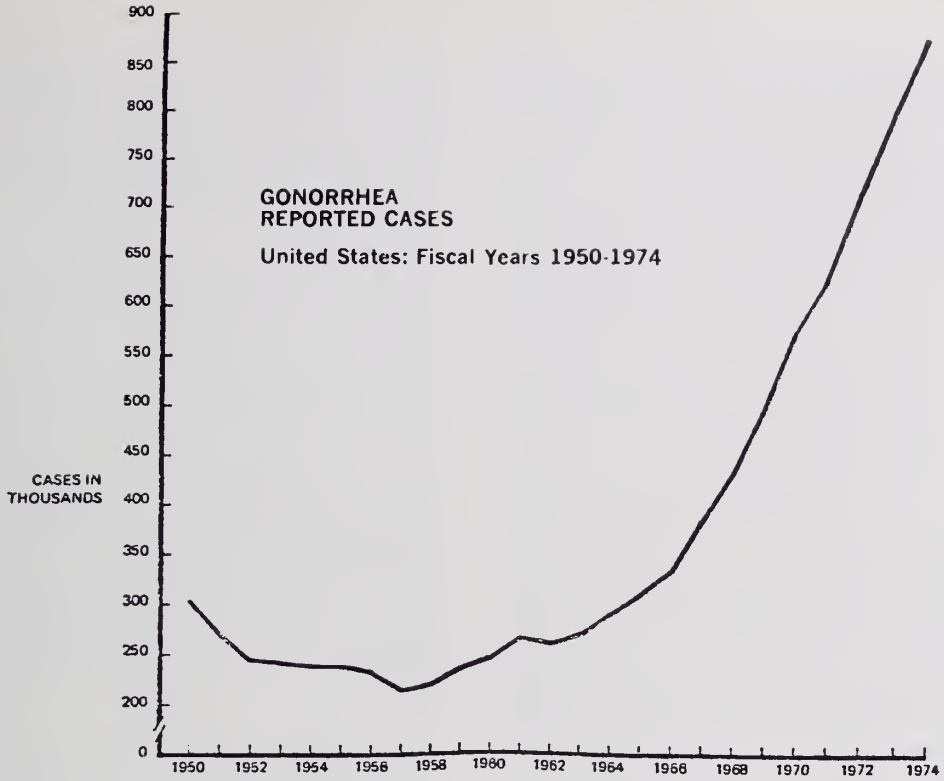
What has happened to change so dramatically the downward trend in venereal diseases observed up to 1957? It had looked as though penicillin would eradicate them as completely as smallpox, but it did not happen. And when a steady increase began, health authorities blamed it on withdrawal of funds and the resulting relaxation of control efforts. They correlated dips and increases with federal appropriations, but it all seemed too pat — and the basic trend was upward (Fig. 2). To examine causes, a more diverse approach is required, ranging from the developing drug resistance in gonorrhea to marked reduction in the use of penicillin as severe allergic reactions became more common. The need for more profound studies of changing demography and social behavior became evident.

Population increases, urbanization and the impact of technology have contributed to significant changes in sexual mores and attitudes regarding marriage and family formation, while the use of drugs and related behavioral aberrations have added to our consternation. As we watch the rising rates of syphilis and gonorrhea, we may find it necessary to revise our traditional concepts of VD control. The early treatment of all contacts and suspects as the principal means of "breaking the chain of infection" may no longer represent the most valid or complete solution to the problem.

Syphilis confers very little immunity upon its victims although immune or allergic responses occur as part of the disease process. Indeed, they may determine the successive stages through which the disease progresses, from chancre through secondary rash and latent phases to the various late manifestations of skin, bone, cardiovascular and neurological disease. No vaccine to impart immunity is yet available. James N. Miller, University of California, Los Angeles, has a vaccine which is still experimental but a long way from clinical use. In addition to technical problems involving cultivation of the organism, natural human immunity is so poor that a superinfection can occur in a patient already infected. More importantly, today's rapid therapy, when given in the early stages, allows insufficient time for significant immunity to develop and reinfections which were uncommon in the days of arsenic and bismuth therapy are quite commonplace now. I recall J. Earle Moore of Johns Hopkins stating that the chancre of primary syphilis as a reinfection was a rare bird indeed.

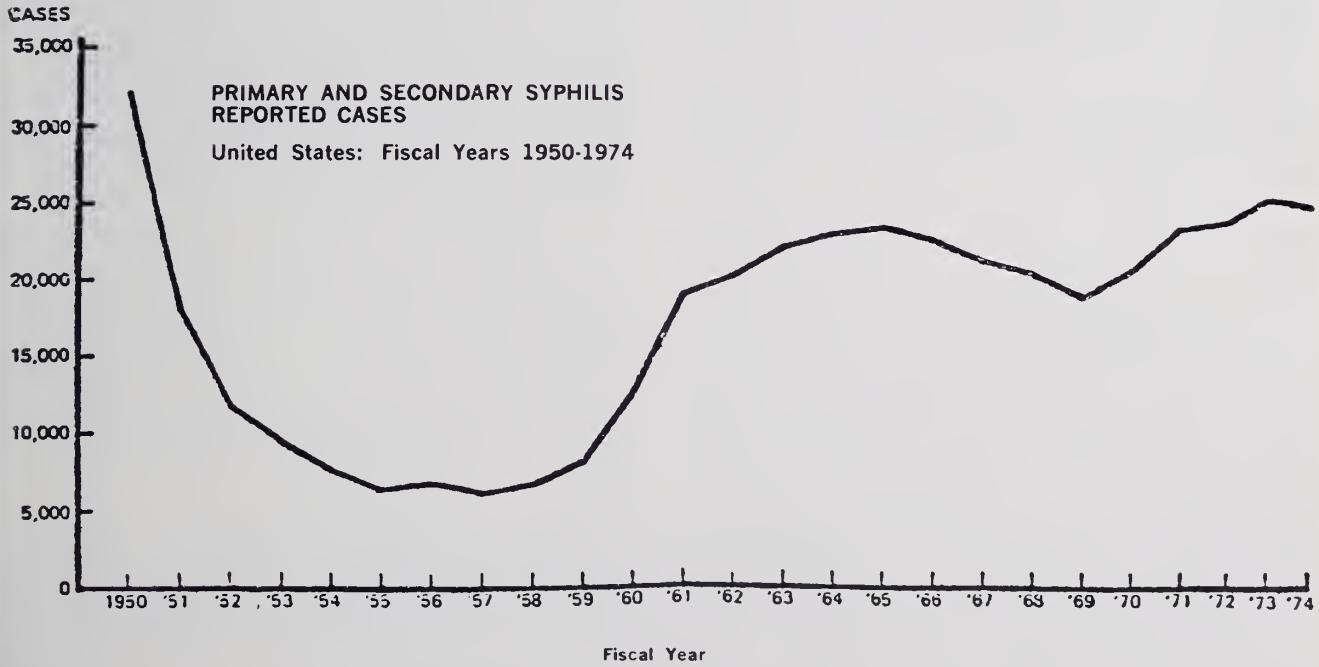
Immunity to gonorrhea is also poor. The three to five day incubation period is so short and transmission so rapid that even the earliest detection and treatment cannot overtake the rapidly spreading disease in a given population.

Reinfections are almost the rule. It is often difficult to establish what is a reinfection and what is a



Source: Public Health Services
Published by American Social Health Association
Figure 1 indicates the marked rise in gonorrhea since 1957, increasing in epidemic proportions from 1962 to 1974.

Figure 1



Source: Public Health Service
Published by American Social Health Association
Table 2 Illustrates the persistent increase in incidence of infectious syphilis from 1957 to 1974.

Figure 2

treatment failure. Indeed, for many individuals, diagnosis, treatment and reinfection is a revolving door. The medical record is a long list of repeated visits.

The asymptomatic nature of gonorrhea presents special problems. In females, infection is commonly accompanied by no symptoms of discomfort, thus permitting continued sexual activity and transmission of the disease. As many as 60% of women infected with gonorrhea are asymptomatic. There had been some doubt about the existence of asymptomatic gonorrhea in males, but recent efforts have uncovered significant numbers. Scraping the anterior urethra with a bacteriologic loop often leads to positive cultures previously missed. Anal cultures in both males and females and throat cultures have uncovered further cases.

Health authorities have pointed out that Thayer-Martin medium on bacteriologic plates has made a significant difference in ability to discover cases of gonorrhea, as has Transgrow holding medium. Media plates must be stored in candle jars until incubated. Transgrow bottles contain their own CO^2. Until recently, Transgrow has been provided without charge to many physicians but limitation of funds has halted this practice and physicians must now provide their own media. More sophisticated methods of diagnosis are under study. An indirect fluorescent technique has been reported as well as serologic tests for gonococcal antibodies. Electron microscopy shows that virulent strains of gonococci possess "pili" and further demonstrates that these pili are antigenic. Hope has therefore been expressed that a vaccine can be prepared based on immune response to these pili. Further, serologic tests or skin tests may also be possible.

For syphilis, the VDRL (Vernereal Disease Research Laboratory) test is still the standard diagnostic and screening test. It is quantitative and the titer is an indispensable aid in evaluating patients for both diagnosis and evaluation of therapeutic response. Where concern for biologically false positive reactions exists, the FTA-ABS (fluorescent treponema antibody absorption) test is available as a more specific confirmatory test. Although more sensitive and specific, it too is susceptible to biologically false positive reactions. Drug addicts frequently produce reactions.

Perhaps many physicians are not aware of the RPR (rapid plasma reagin) test. Its simplicity makes it useful for office, clinic or field use and its rapidity allows almost immediate laboratory confirmation of active disease in contacts or doubtful skin lesions.

Although the American Board of Dermatology no longer includes the word "Syphilology," the dermatologist must still play a significant role in early diagnosis of venereal diseases, not only because of his expert knowledge of skin lesions but also by virtue of his traditional experience with serologic tests for syphilis.

Diagnosis and management still require an intimate knowledge of the sensitivity and specificity of serologic tests as well as where and when they are most useful. Denny L. Tuffanelli, Associate Clinical Professor, Department of Dermatology, University of California at San Francisco, in a brief summarizing article on VD stated, "the patient should not be diagnosed and treated as having syphilis unless the clinical and serological information is as definitive as possible." However, current public health efforts depend heavily upon rapid diagnosis of infectious cases and upon "epidemiologic surveillance and treatment" which are recognized as being the principal means of controlling the spread of syphilis. These methods are turning rising rates downward in localities where they are extensively used.

Dermatologists and all physicians should be obligated to become more current on VD control methods.

Treatment

Penicillin remains the drug of choice for both gonorrhea and syphilis. For gonorrhea, the short-acting aqueous procaine penicillin, which gives high blood levels maintained by the addition of 1 gm. Probenicid, is still recommended in a dose of 4.8 million units for both men and women, given at a single visit. In spite of increasing gonococcus drug resistance, this dosage has been shown to be effective. In addition, it will abort incubating syphilis.

For syphilis, the long-acting benzathine penicillin G is preferred. It is not effective against gonorrhea. Two point four million (2.4 million) units for early infectious syphilis is given at a single session. From 6 to 9 million units given to latent syphilitic patients in three weekly sessions will protect against late syphilis, i.e., cardiovascular and neurosyphilis. No resistance to penicillin has been noted in the Treponeme.

Effective treatment schedules for all stages of syphilis and all complications of gonorrhea are available from health authorities and need not be repeated here. Alternative antibiotics where needed are discussed in these schedules. Follow-up serologic examinations are a necessary part of therapy and the degree of response is useful in confirming the stage of disease at the time of treatment. Treat-

ment failures and especially reinfections are not uncommon.

The other three traditionally accepted venereal diseases are not considered much of a threat at this time. As a practical matter, laboratory aids for their diagnosis are not commonly used. Diagnosis is by clinical evaluation and exclusion. Chancroid is generally quickly cleared by sulfonamides or tetracycline. Lymphogranuloma venereum and granuloma inguinale clear rapidly with tetracycline. Again, detailed treatment schedules are also available for these diseases. More threatening and more complex is herpes simplex virus infection, now considered one of the venereal diseases. Once more, the dermatologist is called upon for clinical evaluation and management. Laboratory aids are frequently cumbersome and slow or difficult to assess. The value of dye plus light therapy, use of idoxuridine, new vaccines, and topical medication must be within the expertise of the physician who must deal with them frequently.

Except for trichomonas infections, other diseases which may be included with the venereal diseases are also essentially skin diseases. Molluscum contagiosum requires perceptive recognition. Management is simple. Once recognized, treatment may be simple unless it involves a heavily infected small child. Mollusca in adults usually present as giant solitary or scant patches over the mons and groin area and are often venereally transmitted.

Scabies is decidedly on the way back. It must be considered among the diagnoses of venereal skin problems. Perhaps routine examination for other venereal diseases is in order when finding scabies. After about 20 years of quiescence, it again must be considered where an itching papular eruption appears under conditions of intimate contact and the distribution of crusted papules around genitalia, buttocks, elbow, wrist and finger webs is observed. Pediculosis pubis and monilial infection may also be added to the list of venereal contact diseases.

The explosive rise in the common venereal diseases and the recrudesence of lesser infections as mass phenomena are evidence of sociologic changes characteristic of our time. As long as 1948, Stokes and Beerman postulated that only an effective vaccine would finally conquer venereal disease. In the meantime, since vaccines do not exist, these authors, the Public Health Service and other authorities managing venereal diseases have agreed that the principle modes of attack will continue to be traditional and well-developed techniques for early diagnosis, use of available, clinical and laboratory aids, contact tracing, interviewing, maintaining sufficient numbers of clinic facilities and interested physicians who offer surroundings conducive to early treatment and epidemiologic treatment as advocated by health departments.

In facing these problems, physicians must recognize the tempo of our times. They must not shrink from offering all available services and, above all, they must not render moral judgments. Treatment must be easy to obtain, inexpensive, and uncritical. All of this must be considered only a holding action until venereal disease can truly be pushed back. We have no other choice.

▶ Dr. Ross, 14705 Southwest 83rd Avenue, Miami 33157.

Happiness is a sunbeam which may pass through a thousand bosoms without losing a particle of its original ray; nay, when it strikes a kindred heart, like the converged light upon a mirror, it reflects itself with doubled brightness—it is not perfected until it is shared.

—Jane Porter

Herpes Progenitalis and Condyloma Acuminata

Richard C. Childers, M.D.

Physicians of all specialties and interests are becoming more involved with the hazards of sex. Adding to the demands already made upon them are the increasing frequency of venereal disease transmission, the new faces these diseases present, complications not previously considered, and new treatment.

The major venereal diseases are well respected and aggressively treated. Syphilis is invariably considered in most diagnostic dilemmas and intensely squelched with penicillin if in the least suspected. Gonorrhea is likewise bombarded with antibiotics at the first suggestion of a drip or question of a contact.

This sensitized and potent attack contrasts sharply with the approach to minor venereal disease such as herpes progenitalis and condyloma acuminata. Familiarity with these diseases has lagged — evidenced by a review of the former in an infectious disease journal[1] which referred to it as "herpes gestationis," a clinically and etiologically separate entity, and the dearth of investigative studies of the latter.

However, by force of their growing frequency, we are slowly being alerted to their significance and nudged toward effective and aggressive management to minimize their morbidity and prevent their newly recognized complications.

Herpes Progenitalis

Herpes progenitalis is an infectious venereal disease easily transmitted when lesions are present and intimate with a recipient mucosa. The infectious rate of around 75% explains in part the spreading popularity of this disease.[2] The responsible agent is Herpesvirus hominis, a DNA virus. Herpes virus types I and II, separable by in vitro culture characteristics and antigenic determinants,[2] were previously believed to be responsible for herpes labialis and herpes progenitalis respectively, but the clinical separation no longer holds.[3] As the operational definition of genitalia is expanded, type I virus is found more and more frequently below the waist.

The primary infection with the virus is characterized by many and widespread red-based vesicles in the affected area. There is often intense edema, tenderness, adenopathy and fever; however, the most common clinical presentation is the recurrent lesion. The virus probably resides dormant in sensory nerves and ganglia[4] awaiting activation by any of a variety of events from trauma to emotional turmoil. Depending on the patient, and probably a host of unknown variables, the recurrences may occur at any time, from weekly to yearly intervals or even less frequently.

The recurrence is often heralded by a brief and mild discomfort interpreted variously as pain, pruritus, or tingling. This is soon followed by closely grouped red papules which rapidly progress to red-based vesicles. The latter are often not seen, being unroofed by incidental or purposeful friction, but leaving a still characteristic clinical picture of grouped redbased crusted shallow erosions, each no more than a few millimeters in size, and the whole cluster seldom encompassing more than a few centimeters of skin. Tenderness and local adenopathy may be present.

The clinical presentation overwhelmingly suggests the diagnosis when present in classical form; in questionable cases the diagnosis can be made with a biopsy or more simply by a Tzanck smear. The latter is a Wright's stain of the isolated cells scraped from the roof and base of the vesicle. Diagnostic multinucleate giant cells are easily demonstrated. Viral isolation is an unreasonable diagnostic tool at present — seldom available to today's physician.

The physical discomfort, emotional distraction and functional disruption of frequently recurring genital disease has led physicians and patients to a bewildering array of therapies. Yet, it is the newly associated risks that have provided the stimulus for active effective research of the disease.

Popular in lay and professional literature is the accumulating evidence that herpes progenitalis is associated with squamous cell carcinoma of the cervix. Investigations have shown herpes virus antibodies to be more frequent and of higher titer in groups more subject to cervical carcinoma, for in-

stance in prostitutes as opposed to nuns.[5] Herpes antigen has been detected in exfoliated cervical carcinoma cells[6] and herpes simplex virus cultured from degenerating cervical carcinoma cells.[7] The evidence is overwhelming for association, but cause and effect remain conjecture. One dissenting view reported changes of herpes in Pap smears of patients with cervical carcinoma; however, changes of carcinoma preceded changes of herpes infection.[8]

A perplexing clinical situation arises when herpes progenitalis occurs during pregnancy. Another human being is at risk and, because of the immaturity of infant host defense, the risk is great. If a mother has active genital herpes at the time of delivery, there is a 40% chance the infant will be infected. If herpes progenitalis is present any time after the 32nd week, 10% to 20% of neonates will be infected. Whether the infection is local, disseminated or asymptomatic, one half will die, be blind or have permanent neurological deficits.[9]

Most evidence suggests infection by passage through the birth canal, making C-section appropriate management. The fact that retrograde infection can occur is supported by the inefficacy of C-section after the membranes have been ruptured for more than four hours.[10] Infection probably also occurs in utero via viremia.[11]

Antiviral therapy is modest, to say the least. The need is urgent. Herpes progenitalis provides an excellent model for research, being an accessible and common viral disease. Recent studies have demonstrated two experimental but very hopeful topical therapies for this disease.

Proflavine or another of the heterotricyclic dyes in combination with photostimulation will inactivate herpes virus.[12-41] When used topically on herpes simplex lesions with light exposure, it is said to decrease the healing time, decrease discomfort and, more important, decrease the probability of recurrence. A major objection to this treatment has abruptly halted its widespread use.[15] The objection is theoretical, stating that the imperfect virus created by the treatment may be itself oncogenic. This is refuted by the argument that if the virus is left untreated it will have many progeny, the vast majority of which are imperfect and therefore cause an even greater risk of oncogenesis.[16] It is hoped that carefully accumulated clinical experience will salvage an effective therapy from theoretical ostracism.

The second experimental therapy is topical iododeoxyuridine (IDU). This agent is of proven value in herpes keratitis and may be of value in treating herpes progenitalis. Combining IDU with dimethyl sulfoxide (DMSO) to increase epidermal penetration has been reported with encouragingly successful results.[17] DMSO, however, is still a carefully controlled experimental drug, just recently given amnesty after an abrupt but brief exile.

Until these or other treatments are proven safe and effective, management of herpes progenitalis will remain symptomatic and dependent upon effective counselling and careful monitoring.

Condyloma Acuminata

Condyloma acuminata is commonly recognized and frequently neglected by patient and physician. It is caused by a papova virus closely related but antigenically distinct from the common wart virus. The disease is transmitted by venereal contact with two thirds of contacts developing lesions within 3.1 months.[18]

The lesions appear as warts on or near the genitalia. Usually they are small digitate papules sprinkled over the involved area, and as such cause no functional problems. Some, however, become large and by nature of their growth rate and location create concern in patient and physician and are finally treated.

New sexual variations have brought new clinical variations. Lesions have been found on oral tissue[19] and even reported to be present on the synthesized genitalia of a transexual ecdysiast and prostitute.[20] Complications from these common tumors are uncommon. Nonetheless they are very important, clearly dictating aggressive therapy for the early and banal appearing wart.

A well known problem with venereal warts is their inclination to involve the urethra or anus. From here they can continually seed distally, bleed, ulcerate or cause frank obstruction. The warts have been found as high as the bladder wall.[21]

The giant condyloma described by Lowenstein and Buschke as a condyloma with the aggressive characteristics of invasive squamous cell carcinoma has now been reported in males and females and with metastases as well as destructive invasion.[22] A growing popular view is that it is not at all a condyloma acuminata but squamous cell carcinoma simulating venereal warts in its early stages.[23] Nonetheless, malignant "degeneration" of small common condyloma accuminata has been reported.[22]

Another possible complication is a high incidence of laryngeal papillomas in the offspring of mothers with condyloma acuminata.[24] These papillomas are histologically similar to condyloma but viral etiology

has yet to be proven. The evidence suggests that the neonate is infected as it passes through the birth canal. If confirmed, this association will demand immediate aggressive therapy of venereal warts in pregnant women. This is no simple task, for the warts often achieve huge proportions during pregnancy and treatment with podophyllin may be hazardous to the infant.[19]

As with herpes virus, there is no specific antiviral agent effective in condoyloma acuminata. Unlike herpes simplex, there is widely used effective treatment—destruction of the host cells for the virus by chemicals, cutting, burning, and freezing.

The latter at times fail. Dramatic results with these persistent failures have been achieved by immunotherapy with auto-inoculation of antigenic material from autologous condylomas.[25] The few reported successes with this experimental technique are particularly encouraging since the subjects were chosen for their resistance to standard treatment.

Conclusion

As the world's puritanical inhibitions are replaced by sexual liberalism, so must our treatment of venereal disease by abstinence and sublimation be replaced by prompt and effective intervention. The approach to venereal disease must also be adequately flexible to accommodate the changing features of these diseases, as is clearly demonstrated by our expanding understanding of herpes progenitalis and condyloma acuminata.

References

1. Wenner, H. A.: Virus Diseases Associated with Cutaneous Eruptions, Progr. Med. Virol. 16:269, 1973.
2. Rawls, W. E., and Gardner, H. L.: Herpes Genitalis: Venereal Aspects, Clin. Obstet. and Gynecol. 15:912, 1972.
3. Chang, Te-Wen et. al.: Genital Herpes, JAMA 229:544, 1974.
4. Docherty, J. J., and Chopan, M.: The Latent Herpes Simplex Virus, Bacteriol. Reviews 38:337, 1974.
5. Nahmais, A. J. et. al.: Epidemiological Studies Relating Genital Herpetic Infection to Cervical Carcinoma, Cancer Research 34:1111, 1974.
6. Hollinshead, A. C., and Tarra, G.: Soluble Membrane Antigens of Lip and Cervical Carcinoma Reactivity with Antibody for Herpes Nivirion Antigen, Science 179:698, 1973.
7. Aurelian, L. et. al.: Herpes Virus Type II Isolated from Cervical Tumor Cells Grown in Tissue Culture, Science 174:704, 1971.
8. Amstey, M. S. et. al.: Herpes Virus Cervicitis and Cervical Neoplasia, Cancer 32:1321, 1973.
9. Nahmais, A. J. et. al.: Significance of Herpes Simplex Virus Infection During Pregnancy, Clin. Obstet. and Gynecol. 15:929, 1972.
10. Hanshaw, J. B.: Herpes Hominis Infections in the Fetus and the Newborn, Am. J. Dis. Child. 126:546, 1973.
11. Montgomery, J. R. et. al.: Congenital Anomalies and Herpesvirus Infection, Am. J. Dis. Child. 126:364, 1973.
12. Friedrick, E. G.: Relief for Herpes Vulvitis, Obstet. Gynecol. 41:74, 1973.
13. Kaufman, R. H. et. al.: Herpes Genitalis Treated by Photodynamic Inactivation of Virus, Am. J. Obstet. and Gynecol. 117:1144, 1973.
14. Felber, T.: Photodynamic Inactivation of Herpes Simplex, JAMA, 223:289, 1973.
15. Medical News: Photoinactivation of Herpesvirus May Be Clinically Hazardous. JAMA 225:459, 1973.
16. Melnick, J.: Photoinactivation of Herpes Simplex Virus Continues to Look Promising, JAMA 226:79, 1973.
17. Dawber, R.: Idoxuridine in Herpes Zoster with DMSO, Br. Med. J. 2:526, 1974.
18. Powell, L. C.: Condyloma Acuminatum, Clin. Obstet. and Gynecol. 15:948, 1972.
19. Summers, L., and Booth, D. R.: Intraoral Condyloma Acuminatum, Oral Surg. 38:273, 1974.
20. Fiumara, N. J., and Mattia, A. D.: Gonorrhea and Condyloma Acuminata in a Male Transexual, Br. J. Ven. Dis. 49:478, 1973.
21. Bissada, N. K. et. al.: Extensive Condyloma Acuminata of the Entire Male Urethra and the Bladder. J. Urol. 112:201, 1974.
22. Fitzgerald, D. M., and Hamit, H. F.: Variable Sigificance of Condylomata Acuminata, Ann. Surg. 179:328, 1974.
23. Kovi, J., et. al., Malignant Transformation of Condyloma Acuminata, Am. J. Clin. Path. 61:702, 1974.
24. Cook, T. A., et. al.: Laryngeal Papilloma: Etiologic and Therapeutic Considerations, Ann. Otol. 82:649, 1973.
25. Powell, L. C., et. al.: Treatment of Condyloma Acuminata by Autologous Vaccine, South. M. J. 63:202, 1970.

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The Everyday cares and duties, which men call drudgery, are the weights and counterpoises of the clock of time, giving its pendulum a true vibration and its hands a regular motion; and when they cease to hang upon the wheels, the pendulum no longer swings, the hands no longer move and the clock stands still.

—Longfellow

Mighty Mites and Other Bug Bites

J. Kent Bartruff, M.D.

Scabies

Scabies is caused by the itch mite, **Sarcoptes scabiei.** Only one species (variety **hominis**) is communicable but animal species occasionally cause an atypical scabies rash in humans. Although scabies became a rarity in the early 1950s, since 1964 its worldwide incidence has continued to rise for reasons not fully understood.[1,5]

The adult female burrows into the stratum corneum after fertilization has occurred on the skin surface. She extends the burrow, lays one to three eggs daily for up to two months, and then dies. The eggs hatch in two to three days and the larvae migrate to the skin surface, reaching maturity in two to three weeks. The male mites live in the skin fold areas and die after copulation.

Scabies is transmitted by close personal contact. In a previously unaffected person, it takes one month after mite infection before the typical cutaneous lesions appear. During this time the patient is an asymptomatic carrier. The rash and pruritus are believed to represent a hypersensitivity reaction to the mites. Itching is worse at night, perhaps because the warmth of bed clothes stimulates the mites to increased activity. The most frequently involved areas are the fingerwebs, anterior surfaces of the wrist, elbows and the male genitalia. In infants and small children scabies may also involve the face, palms and soles. The rash in infants may mimic eczema or atopic dermatitis.[2]

To diagnose scabies one must demonstrate a classic burrow, mite, ovum, or fecal compactions (scybala). Burrows range from several millimeters to a few centimeters in length and may be identified with the aid of a magnifying glass. Unfortunately, by the time a patient seeks medical attention he has usually obliterated the burrows by scratching. The mite, egg, or scybala may be seen by examining skin scrapings through a microscope. Most textbooks suggest examining the debris on a glass slide with potassium hydroxide (KOH) solution. However, the KOH stops all movement by killing the female mite and also dissolves the fecal material. The best method is to place a drop of mineral oil on a scalpel blade and then scrape a burrow or papule. The scrapings adhere to the oil, thus yielding more material for examination, and the scybala will not dissolve.[3] This method is successful in approximately 75% of patients if the lesions are carefully selected.

Gamma benzene hexachloride (Kwell) lotion is the most extensively used scabicide. Crotamiton (Eurax) and benzyl benzoate are also popular. The key to successful therapy lies in treating simultaneously all family members and all close contacts. The scabicide is applied from the neck downward, with particular attention to hairy areas around the groin and perianal region. It should remain in contact with the skin for 24 hours and then thoroughly washed off. Following this, all members should wear freshly washed clothing. Although one application is usually curative, it is generally recommended that Kwell be reapplied after one week.

Since the vast majority of pruritic excoriated papules of a scabetic eruption represent a hypersensitivity response to mite by-products rather than actual local infestation with mites, slow resolution of pruritus and inflammatory papules does not necessarily indicate persistence of active infection. A pruritic eczematous eruption may persist for two to three weeks after elimination of the mites. Resolution of the residual eruption may be speeded by application of topical steroid creams and oral antihistamines to allay the pruritus. Occasionally topical or systemic antibiotics are requested to combat bacterial superinfections such as furunculosis of allulitis.

Apparent therapeutic failures are usually due to failure to follow instructions in application technique, failure to treat all affected members or contacts, or reinfection from an outside source. If scabies is found in one member of a group, the entire group must be treated to eliminate the mites.

Larva Migrans (Creeping Eruption)

Creeping eruption is caused by the larvae of **Ancylostoma braziliense,** a helminth which infects dogs and cats. The organisms are found in soil and sand which have been contaminated by excreta from these animals. After entering the skin of the hand or the sole of the foot the larvae burrow and migrate under the skin, leaving an elevated, erythematous serpiginous tunnel. Thiabendazole is usually cura-

tive in oral dosage of 25 mg. kg. of body weight (maximum, 1,500 mg.) twice a day for two days, but may cause nausea, vomiting or dizziness. Retreatment of residual lesions with topical thiabendazole may be necessary.

Anoplura (Sucking Lice)

Sucking lice may parasitize human beings in three forms: (1) head louse **(Pediculus humanus** var. **capitis)**, (2) body louse **(P. humanus** var. **corporis)**, (3) public or "crab" louse **(Phthirus pubis.**

Pediculosis capitis is most commonly found in children or youths with longer hair styles. The head lice are usually confined to the scalp and scalp hair Gamma benzene hexachloride (Kwell) shampoo is effective treatment. The hair is wetted thoroughly with warm water and one ounce (30 cc.) of the preparation is used for a vigorous four to five minute shampoo. Care should be taken to avoid getting it into the eyes. A thorough rinse is then recommended. Any remaining nit shells may be removed with a fine tooth comb. If necessary, the treatment may be repeated in 24 hours, but no more than twice in one week.

Pediculosis corporis, or vagabond's disease, is usually seen in the aged or in persons with extremely poor personal hygiene. The body louse resides in, and lays eggs near, the seams of clothing. It comes upon the body only to feed, commonly in the interscapular, shoulder and waist regions. Parallel linear excoriations in the interscapular region are almost pathognomonic. The treatment is esentially the same as for scabies.

Pediculosis pubis is confirmed by the presence of nits and lice. The nits are attached to the hairs about half an inch above the skin. Bluish gray spots, maculae ceruleae, are often found on the thighs. They are probably the result of a toxic louse excretion, possibly from the salivary gland. Kwell lotion applied 24 hours or the shampoo used for five minutes is effective. Infestation of the eyelashes may be treated with yellow oxide of mercury or an anticholinesterase preparation such .25% Eserine ophthalmic ointment.[1]

Ticks

Ticks are globular arachnids with short legs, leathery integument and an exclusive adaption for sucking blood from mammals, birds, and reptiles. Ticks cause toxic manifestations, their venom producing hyperemia and hemorrhage. Removal of the offending tick is followed by a rapid subsidence of the elevated temperature and of the associated symptoms, i.e., anorexia, headache, malaise, and at time, abdominal pain and vomiting.

Erythema chronicum migrans may be seen following tick bite. This starts out initially as a small ring of persistent slightly elevated erythema and enlarges peripherally wtih central clearing. It is usually asymptomatic, although itching and burning may be present.

The tick should be removed rather than crushed. Various means are recommended to cause the tick to release itself: a few drops of chloroform applied to the head, application of alcohol or oil, use of a hot nail, tobacco juice or nail polish may be effective. If one cannot avoid highly infested areas, diethyltoluamide (DEET) is effective as a repellent.

Chiggers

Trombiculid mites are known popularly as chiggers, red bugs, or mower's mites. Chigger bites are most common in the summer and fall when humans are in closest contact with mite-infested grass and bushes. The legs and waistline are the preferred bite sites. The lesions are pruritic and consist of a hemorrhagic center surrounded by edema and erythema. Prevention consists of wearing tight-fitting clothes in infested areas. Insect repellants offer some protection. Symptomatic treatment with the following may give relief: antipruritic lotions, lidocaine (Xylocaine) spray or lotion, or spraying individual lesions with ethyl chloride.

References

1. Orkin, M.: Resurgence of Scabies, JAMA 217:593, 1971.
2. Hurwitz, S.: Scabies in Babies, Ar. J. Dis. Child. 126:226, 1973.
3. Muller, G.; Jacobs, P. H., and Moore, N. E.: Scraping for Human Scabies, Arch. Derm. 107:70, 1973.
4. Orkin, M.: Pediculosis Today, Minn. Medicine.
5. Orkin, M.: Today's Scabies, Arch. Derm. 3:1431, 1975.

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Figure 2

Figure 1

Figure 4 (Case 1)

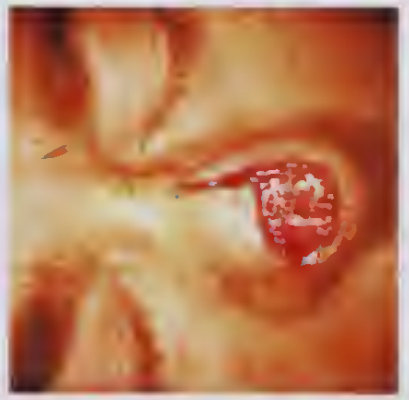
Figure 3 (Case 1)

Figure 2 (Case 1)

Figure 1 (Case 1)







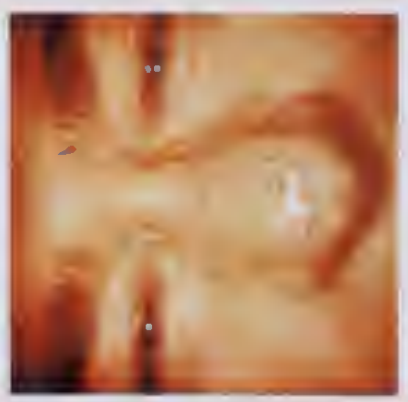


Figure 1









Figure 2









Figure 3









Figure 4

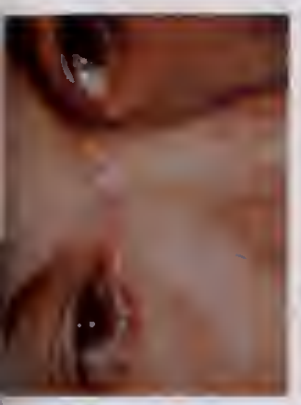


Figure 11 (Case 2)



Figure 14 (Case 3)



Figure 10 (Case 2)



Figure 13 (Case 3)



Figure 9 (Case 2)



Figure 12 (Case 3)

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ORGANIZATION

Position Regarding Medical Professional Liability

The Florida Medical Association was formed in 1874 as a scientific professional organization dedicated to the advancement of medical science and medical services in Florida. This statement has been prepared on behalf of the more than 10,500 physicians of the FMA.

The problem of professional liability insurance coverage and cost has become so intense, it is seriously jeopardizing the delivery of medical care in this state in various manners: physicians are discontinuing the practice of medicine, leaving the State of Florida to practice medicine elsewhere, or declining to start practicing in Florida; semi-retired physicians are discontinuing limited services in retirement villages; and certain types of medical treatment are being discontinued.

As an Association, our initial experience with medical professional liability insurance was the FMA Group Program which was established in 1929 and continued until the late 1940's. This program was based on a master policy under which individual certificates were issued; it was underwritten by three U.S. companies until shortly after World War II when these companies stopped honoring this group plan.

In the early 1950's the FMA established a special committee which was commissioned to work towards the development of an ideal program containing centralized claims handling, centralized coordination of legal defense, peer review for underwriting, and many other novel features. Eight years were spent seeking a responsible company to underwrite this model program. The Employers Group of Insurance Companies of Boston agreed to underwrite the FMA Professional Liability Insurance Plan effective January 1, 1963. The program had a slow development and low participation until the late 1960's when over 20 companies discontinued writing this type of coverage in Florida and participation boomed.

As the program was reaching its peak in participation and implementation of its special features, the Commercial Union Insurance Companies of England purchased the Employers Group of Insurance Companies and terminated all policies December 31, 1972. Negotiations were completed with the Argonaut Insurance Company of Menlo Park, California, to underwrite this group program beginning January 1, 1973 for a period of five years. In February, 1975 Argonaut, forced by its parent company Teledyne, committed a breach of contract, threatened to terminate every physician by March 1, 1975, and levied an illegal assessment of which totaled over $13,000,000 upon the policyholders under this plan. A Federal Court suit resulted over these actions. The Federal Court ruled that the January 1, 1975 premium and individual policies must remain in force until December 31, 1975 and that the illegal assessment be refunded by Argonaut. There is no responsible insurance company which will underwrite the FMA professional liability insurance plan on January 1, 1976 when the Argonaut agreement terminates.

The FMA leadership has acted in a responsible manner by establishing, endorsing and recommending the FMA-Professional Liability Insurance-Trust. As of today, it has received over 4,000 applications from members of the Association. Approximately 2,500 have been underwritten, and policies are being mailed. The Trustees have adopted a sound course of underwriting based upon the most accurate actuarial data available, have established a management company composed of the most competent people in the insurance field available, and have taken every precaution to make this a sound venture.

To insure medical professional excellence, we are continuing our commitment to strict standards for licensure, approved specialty training, mandatory postgraduate education, hospital review and qualification, sponsorship by other physicians, tissue and review committees, and medical peer review. We would like to emphasize that these stringent procedures have all been established from within the medical profession and, further, that no other profession has ever exhibited such self-imposed standards of qualification and review to insure the excel-

lence of its members. The last session of the Florida Legislature has assisted us greatly by giving more powers and responsibilities to the State Board of Medical Examiners.

We believe that every patient who is injured as a result of negligence should be compensated immediately for rehabilitation and damages incurred; therefore, there is a definite need for professional liability insurance. However, this insurance should not be utilized for life insurance, disability insurance, or health and accident insurance, where no negligence exists, and for which no premium has been paid.

We recognize that the overall problem of professional liability is a social problem and cannot be resolved in one fell swoop. However, the spiraling cost of this insurance is passed on to the patient and must be curtailed before it becomes catastrophic.

We believe the following legislation, if enacted into law, would be of definite advantage in curtailing spiraling costs caused by the frequency of claims and the increasing amounts for damages awarded and defense of unwarranted suits:

—A provision for recovery of defense costs in unsuccessful suits

—The determination by a jury of whether negligence exists; the determination by a court appointed compensation panel to determine the amount of damages when negligence does exist; and a definite cap on the amount awarded for general damages; or the determination of negligence be removed from the jury system and placed in the hands of knowledgeable professionals, competent to make such determinations

—A structural settlement of awards and legal fees requiring periodic payments rather than a lump sum payment for such future damages and thus insuring continuous support for the injured patient during his entire disability period

—A statutory definition of medical malpractice (negligence)

—The amount of benefits from any collateral sources to be applied against the total of a settlement in order to rule out duplicate payments

—The elimination of medical expert witnesses who are not licensed, practicing physicians in the State of Florida

—An absolute two-year statute of limitation from date of incident to permit a realistic actuarial determination of the medical malpractice risk and make it possible for private insurance carriers to reenter the State of Florida

—A **Res ipsa loquitur** statute providing that injury alone does not raise a presumption of negligence and that the jury shall be so instructed

—A limitation of contingency fees paid to attorneys

We would like to make observations regarding several other proposals that have recently been espoused:

—We do not believe that a permanent J.U.A. should be considered at the present time when the self-destruct statute was passed only 6 months ago to solve an availability problem. We believe that the formation of the FMA-PLI-Trust and other trusts which have become operational in Florida and supported by the enactment of additional statutory relief will solve the availability problem. In our opinion it would be premature to consider a permanent J.U.A.

—We believe a mandatory patient's compensation fund, would be a needless form of government intervention; reflect an obvious discrimination against the physician; would be most detrimental to the free enterprise system on which our country was founded; and result in an inequitable tax administered by the state for the privilege to practice medicine.

—A careful look must also be taken at the proposed patient's rehabilitation fund to compensate every individual who has an untoward result not based upon any negligence. This would represent a rehabilitation and welfare program which could only result in untold economic proportions.

We trust that the final deliberation of The Florida Medical Liability Study Commission, established by the 1975 Florida Legislature, will contain specific recommendations directed at curtailing the spiraling cost of professional liability insurance. The FMA has acted in a responsible and positive manner to help resolve the availability problem; however, the final solution to the problem, which is needed in the immediate future, will come only with the further understanding and assistance of the Florida Legislature.

Respectfully submitted,
Vernon B. Astler, M.D.
President

December 10, 1975

House of Delegates To Convene In Orlando

The House of Delegates of the Florida Medical Association will convene in interim session at Orlando's Hyatt House Hotel, at Kissimmee, on January 30 to consider FMA's 1976 legislative program and certain other important issues. Former Governor Ronald Reagan, of California, will be a speaker at a related meeting.

Two meetings of the House will be the focal point of four days of FMA meetings beginning on Thursday, January 29.

There will be two reference committees of the House, as compared with five at the regular annual meetings, with one to devote its entire attention to legislation. The second reference committee will take testimony on a handful of miscellaneous topics.

The House will convene at 2:00 p.m. on January 30 for the customary formalities. Reference Committees will meet at 9:00 a.m. the following day and will file their reports for action by the House at its second and final session at 9:00 a.m. on Sunday, February 1.

Reference Committee I (Legislation) will be chaired by Richard C. Clay, M.D., of Miami. Serving with him will be Jack W. MacDonald, M.D., of Tallahassee; Sanford A. Mullen, M.D., of Jacksonville; Harold L. Williamson, M.D., of Tampa; and Robert J. Brennan, M.D., of Ft. Lauderdale.

J. Wayne Hendrix, M.D., of Port St. Joe will chair Reference Committee II, which is to consider the President's proposed assessment of the membership to finance legislative and public relations activities; proposed changes in the Association's continuing medical education program; and a modification of the Association's existing policy on physician telephone directory listings.

Other members of Reference Committee II will be John C. Fletcher, M.D., of Tampa; Richard B. Moore, M.D., of West Palm Beach; William M. Straight, M.D., of Miami; and Philip B. Phillips, M.D., of Pensacola.

The continuing medical education issue involves a recommendation of the Council on Scientific Activities that FMA adopt the criteria for the American Medical Association's Physicians Recognition Award when the first three-year cycle of the present state program ends on December 31, 1976. The Board of Governors approved placing the item before the House in January without making any recommendation of its own on the merits of the proposal.

A recommendation from the Board will ask the House to limit telephone directory yellow page specialty headings to those specialties and sub-specialties for which there are recognized certifying boards.

The Florida and American Medical Political Action Committees (FLAMPAC and AMPAC) will sponsor a Political Education Seminar on Friday morning, January 30, beginning at 8:30. Among the speakers will be Florida Congressman Louis Frey, Jr., and Illinois Congressman Robert H. Michel.

FMA will conduct a General Session on Saturday afternoon at 2:00. Governor Reagan, an announced candidate for the Republican presidential nomination, will be the keynote speaker.

Several FMA committees and councils are planning business meetings beginning on Thursday, January 29. These include the Judicial Council, the Committee on Continuing Medical Education and the Committee on Scientific Publications.

Florida Supreme Court Considers Contingency Fee Modification

The Florida Supreme Court conducted a hearing on January 14 on proposed modifications of the contingency fee rule of the Florida Bar.

The Florida Medical Association put a petition before the court as did the Florida Bar and the Academy of Florida Trial Lawyers (plaintiff's attorneys.)

According to some legal sources, the contingency scale suggested by the Bar probably does not differ significantly from what is already charged by plaintiff's attorneys. Under the Bar plan, an attorney would get one-third of any settlement reached before suit is actually filed; 40% of the award at trial or after a suit is filed; 45% if the case is appealed; and 25% of that part of any recovery that exceeds $500,000.

In his petition on behalf of FMA, Tallahassee attorney W. Robert Fokes called the Supreme Court's attention to a New Jersey plan which allows lawyers to collect half of the first $1,000 recovered, scaled down to 10% on any amount recovered over $100,000.

"The New Jersey Rules provide that an attorney can obtain a court hearing to request a higher fee if the limitations result in an inadequate fee," the FMA petition said.

The amendment suggested by the Bar is "much too high to bring about the improvements which are sought in this proceeding," FMA stated. "The difficulty is that as long as a high contingent fee is possible there will be some who will file claims where no liability exists and the expense of defending such actions, although the defense is ultimately successful, will reflect itself in the insurance rate on malpractice insurance."

The trial lawyers advised the court to "carefully and critically scrutinize the motives of the 'professional defendants' who seek to restrict attorneys fees." Its petition continued:

"The clamor by medical associations, insurance companies, lobbyists for railroads, trucking interests, manufacturers' associations, and similar entities should be recognized for what they are: attempts to reduce the number of claims paid by making it difficult or impossible for legitimate claimants to obtain legal representation; attempts to avoid legal responsibility for negligence and fault . . ."

However, the trial lawyers admitted "that, in a limited number of circumstances, there have been abuses of the contingent fee system by a limited number of lawyers involving, hopefully, a limited number of clients."

Developments from this meeting will be published in a future issue of the Journal.

Grant Program for Continuing Education In Obstetrical Care

The American College of Obstetricians and Gynecologists is administering a grant program for continuing education conferences in obstetric-gynecologic care.

Objective of the program, funded by the Bureau of Community Services of the Department of HEW, is to insure quality care to all women and healthy childbirths. Educational opportunities would be provided to physicians who are not obstetrician-gynecologists but who do obstetrical cases, and allied personnel such as nurses, midwives, health care workers, etc.

Fellows of the College can initiate CME programs in cooperation with family physicians and/or obstetric-gynecologic nurses.

Information may be obtained by contacting: C. H. Gilliland, M.D., Section Chairman, ACOG, 1100 N. W. 8th Avenue, Gainesville, Florida 32601.

In Memoriam

Reuben B. Chrisman

1911 - 1975

Reuben B. Chrisman, born in Hazel, Kentucky, on August 4th, 1911 the grandson of a Kentucky physician, died on October 13th, 1975 victim of a fire in his home in Coral Gables.

Dr. Chrisman was educated in the public schools and graduated from Murray State Teachers College in his native state. He received his medical degree from the University of Tennessee in 1938 and took his internship and his residency training in OB-GYN at the John Gaston Hospital in Memphis. He was an assistant instructor at the University of Tennessee School of Medicine and was a member of the Memphis-Shelby County Medical Association and the Tennessee Medical Association.

In 1941 he entered the military service in the U. S. Army and served as Chief of Surgery in the Station Hospital, Camp Forrest, Tennessee and eventually rose to command the 220th General Hospital in France. He left the Army in 1946 with the rank of Colonel and moved to Miami.

Always an active and dedicated member of his county society he served on the Medical Education and Hospitals Committee, the Economics and Public Relations Committee, the Editorial Board, the Executive Committee, and was elected Secretary of the Association for two terms. He served in the House of Delegates of the Florida Medical Association for many years.

In the American Medical Association, he became a member of the Florida delegation in 1952 and served with distinction until ill health forced his resignation in 1969. He served as a member of the American Medical Association Committee on Legislation and the Committee on Military Medical Affairs of the Council on National Defense.

Dr. Chrisman was a founder member and served for two years as chairman of the Florida Committee for Better Government, the forerunner of the present FLAMPAC organization.

He became a privileged member of the Association in 1971.

He is survived by his wife Betty, a son Richard, two daughters, Betty Chrisman and Mrs. G. N. McMillan, and three grandchildren. — Richard C. Dever, M.D., Miami.

Reason is like the sun, of which the light is constant, uniform, and lasting; fancy, a meteor of bright but transitory lustre; irregular in its motion and delusive in its direction. — Johnson

WELCOME TO THE LAND OF ABUNDANCE...



...WHERE ONLY ONE PRESCHOOLER IN 20 GETS ENOUGH IRON!

That unnerving—and almost incredible—statistic comes from the recently released first Public Health Service survey designed to assess the nutritional status of the *entire U.S. population.**

So when you encounter the apathy, lethargy, irritability and behavior problems that may telegraph such iron deficiency, consider the need for a diet richer in iron. Or, if diet change is impractical, INCREMIN® with Iron Syrup, a remarkably palatable liquid that encourages patient adherence to your instructions.

*First Health and Nutrition Examination Survey, DHEW Pub. No. (HRA) 74-1219-1, National Center for Health Statistics, Rockville, Maryland. (This report indicates that approximately 95% of the children 1-5 years old had iron intakes *below* the standard set by the Food and Nutrition Board of the National Academy of Sciences.)

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Each teaspoonful (5 cc) contains:

Elemental Iron (as Ferric Pyrophosphate)	30 mg
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Thiamine HCl (B_1)	10 mg
Pyridoxine HCl (B_6)	5 mg
Vitamin B_{12}	25 mcgm
Sorbitol	3.5 gm
Alcohol	0.75%

DOSAGE: Prevention of iron-deficiency anemia—Children and Adults —1 tsp. (5 cc) daily. Treatment of iron deficiency anemia—Children: 1 tsp. t.i.d.; Adults: 1 tsp. q.i.d.

SUPPLY: Bottles of 4 fl. oz. and 16 fl. oz.

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Dorothy R. Mooney, Associate Director

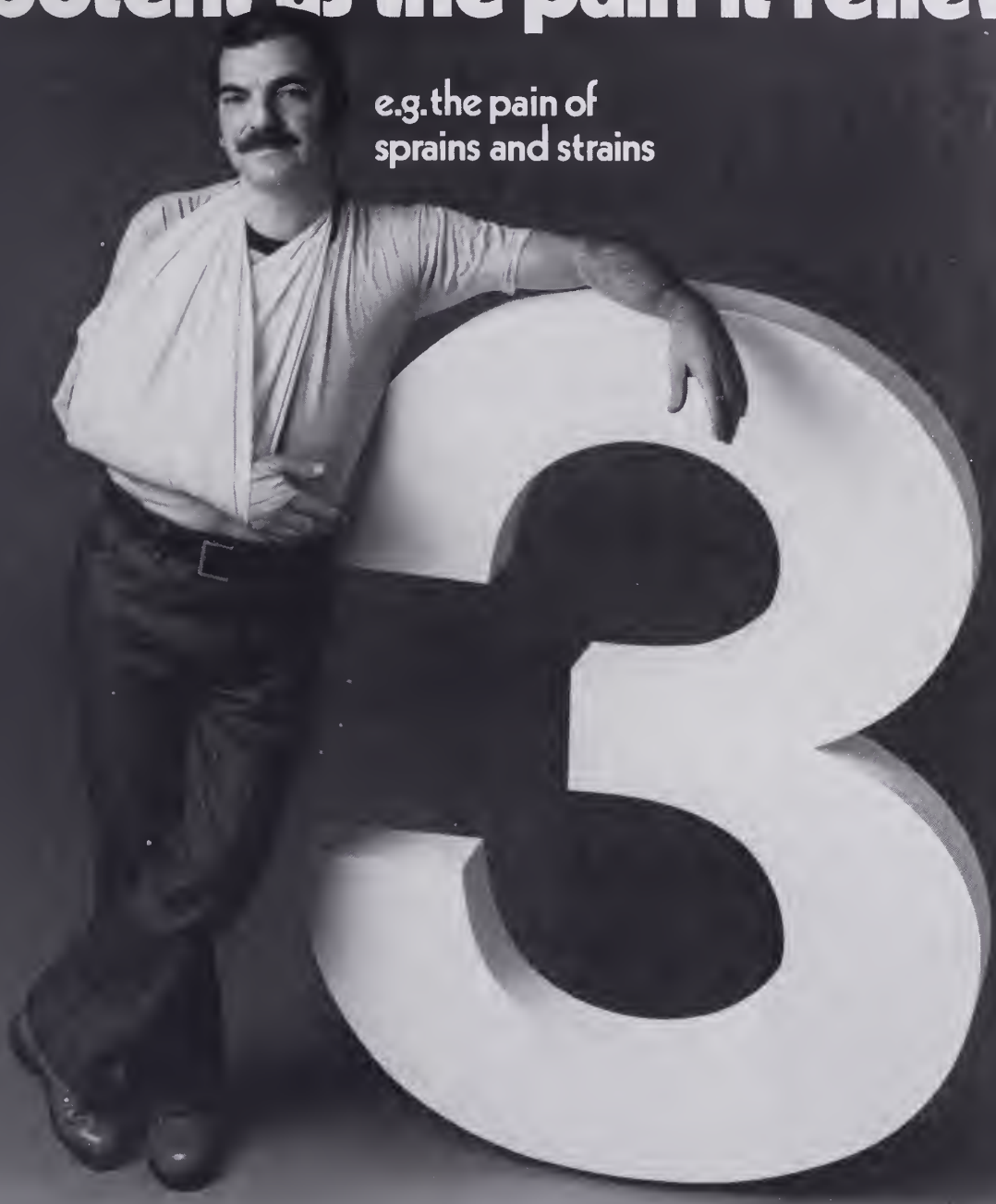
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sprains and strains



NOT TOO LITTLE

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- unlike acetaminophen/codeine combinations, it does not sacrifice anti-inflammatory action

NOT TOO MUCH

- potent—yet not excessive
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NOT TOO EXPENSIVE

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- readily available in both hospital and local pharmacies

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codeine phosphate* (32.4 mg) gr ½
Each tablet also contains: aspirin gr 3½, phenacetin gr 2½, caffeine gr ½. *Warning–may be habit-forming

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Research Triangle Park
North Carolina 27709

Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



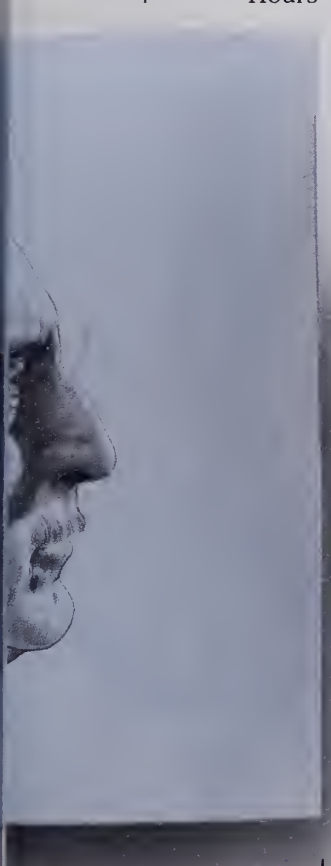
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories.[1-4]

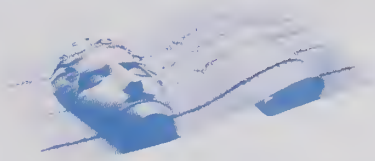
The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

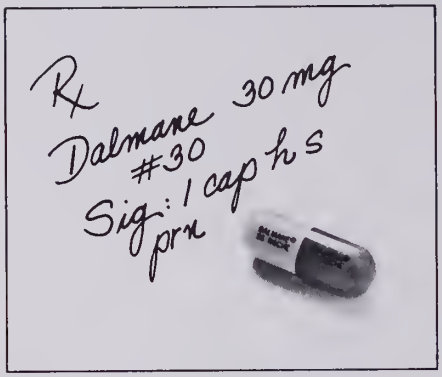
- □ induces sleep rapidly
- □ reduces nighttime awakenings
- □ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ℞ IV



Objectively proved in the sleep research laboratory, Dalmane

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



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ROCHE LABORATORIES
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Are they too old to swing?

EACH TESTAND-B TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg.
Methyltestosterone	1.25 mg.
L-lysine	100 mg.
Nicotinic Acid	12.5 mg.
Iron (from Ferrous Sulfate)	2.82 mg.
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
Ascorbic Acid	25.0 mg.
Folic Acid	0.1 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific. Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets.

TESTAND-B INJECTABLE: VIALS OF 10cc.

Testand-B tablets

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Others Are Saying

TIME IS VALUABLE!

"Seems as though it's impossible to get through to you," I chided a friend of mine the other day. "You have a recording that says, 'Sorry he's in conference at the moment and can't be disturbed.' "

"That's merely because I place a high value on someone else's time," he replied.

"Run that past me once more," I said. "It costs me time when I have to phone you again to reach you."

"Yes, but you don't have an appointment and the man I am talking to has one. When I give an appointment to someone, I intend to give the person full value and my complete attention. It's only fair."

He had made his point.

Last week I cooled my heels in an auto parts store while one of the employees bantered with a friend, instead of waiting on me.

And then a lawyer friend of mine kept me waiting during time I had reserved and paid for, while he talked on the phone with someone else. I could have seen several patients in my own office during the time I wasted. His secretary had given me a specific appointment time and I had accepted it with the assurance that the time would be mine. As a matter of fact, I had cancelled some appointments in my own office in order to meet his **time** requirements.

After leaving his office I went to the hospital to make rounds. I was angry. I was still so upset over my lawyer-induced inconvenience that I reviewed the entire indignity with a colleague in the doctors' lounge, making me an additional half hour late for my afternoon office appointments.

When I got to the office, my nurse greeted me with: "Doctor, you have five patients inside waiting for you." Suddenly, the irony of its struck me. I was doing to my own patients exactly the same thing I had complained about in the auto parts store and in my lawyer's office.

I sneaked a cracked-door look at my waiting room to see just whom I had inconvenienced. There sat the following patients:

- A school teacher for whom a substitute had to be hired to fill in while she waited to see me.
- A young mother who had to hire a baby sitter from her meager budget while she waited to see me.
- An executive who had canceled all appointments for the afternoon to wait for me so that he and his wife could discuss her upcoming surgery.
- An auto mechanic who was losing considerable wages while he waited with his wife to see about a threatened miscarriage.
- A housewife who may have had other things to do, rather than wait while I vented my feelings to my colleague in the hospital cloak room.

Yes, our time is valuable. True, we are on call 24 hours a day, and many times we are called away on emergencies. But this is not always the case, nor is it an excuse for poor scheduling.

What does it really cost to see a doctor? I don't mean the charge for the office visit. I refer to the cost to patients in lost wages, lost time, even lost patients with doctors who keep them waiting unnecessarily.

We all have the same size "suitcase": a 24-hour day, which we are allowed to pack in any way we see fit and with whatever items we choose. Time means different things to different people. A prisoner sitting out a life sentence has a viewpoint different from that of a man rushing to catch a plane.

But perhaps we can schedule our 24 hours of time better, leaving out certain nonessentials and rearranging what is left in a more orderly fashion to render full value to those who have "bought" that time.

If we overschedule, we are shortchanging those patients who have purchased some of it in good faith. Admittedly, some areas are understaffed with doctors. Surely we must arrange our appointment books so that we don't have to wait for patients. But if we know we will be two hours late, let's permit the patients to come two hours later. Let's save their time, too.

Today, in our ecology-minded culture, let us remember that time is one valuable commodity that cannot be recycled—whether it is our own time or the time that rightfully belongs to our patients.

Lindsey R. Curtis, M.D.

Dr. Curtis is Assistant Clinical Professor of Obstetrics and Gynecology, University of Utah College of Medicine, Salt Lake City.

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Entrapped gas...

Silent partner of GI spasm

Painful GI spasm in the presence of entrapped gas causes even more pain and more discomfort. Yet, while spasm is relieved, entrapped gas often goes untreated.

Not so when you prescribe Sidonna. Sidonna helps release entrapped gas with specially activated simethicone, a nonsystemic antiflatulent, while also helping to relieve spasm with a traditional combination of belladonna alkaloids. And Sidonna provides mild sedation with butabarbital.

Sidonna. The therapeutic partnership approach to functional or organic GI disturbances including spastic colon, irritable bowel syndrome, gastroenteritis, gastritis, peptic ulcer and nervous indigestion.

Contraindications: hypersensitivity to barbiturates or belladonna alkaloids; glaucoma, prostatic hypertrophy, pyloric obstruction. **Side Effects:** dry mouth, blurred vision, dysuria, skin rash, constipation or drowsiness. **Dosage:** one or two tablets preferably before meals and at bedtime.

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Each scored tablet contains: specially activated simethicone 25 mg., hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg. (equivalent to belladonna alkaloids [as bases] 0.1049 mg.) and butabarbital sodium N.F. 16 mg. (Warning: may be habit forming.)

A working partnership against the pain of gas and spasm

There's something special about children vomitin

The risk of dehydration . . . plus the psychological stress on both mother and child . . . greatly increases the urgency in controlling vomitin in children. In addition, there is, of course, need to avoid the extrapyramidal problems associated with phenothiazine medications.



That's why special medication is preferred

WANS® CHILDREN SUPPRETTES™ are specially formulated to stop vomiting and nausea in children—rapidly and with minimal complications.

- WANS are administered rectally—often the best route in the vomiting patient.
- The exclusive WANS formula provides both pyrilamine maleate and sodium pentobarbital for effectiveness . . . contains no phenothiazines or local anesthetics.
- The unique Supprette delivery system rapidly releases effective levels of medication . . . with no oils or fatty acids to affect absorption or cause local irritation.
- WANS SUPPRETTES require no refrigeration . . . no lubrication other than water . . . and dissolve completely, with virtually no leakage.

And for children over 12 years of age and adults suffering from nausea and vomiting, consider higher-strength WANS® No. 1 or WANS® No. 2.

A special favorite* of Florida physicians in controlling childhood vomiting



WANS® CHILDREN SUPPRETTES™

rectal antinauseant/antiemetic

pyrilamine maleate 25 mg; sodium pentobarbital 30 mg
Warning: may be habit forming

*Based on usage by dosage form; data gathered by independent research organization.

DESCRIPTION: WANS* Children: (Blue) pyrilamine maleate 25 mg and pentobarbital sodium* ½ gr (30 mg) scored for ½ dosage. WANS* No. 1: (Pink) pyrilamine maleate 50 mg and pentobarbital sodium* ¾ gr (50 mg) scored for ½ dosage. WANS* No. 2: (Yellow) pyrilamine maleate 50 mg and pentobarbital sodium* 1½ gr (100 mg) scored for ½ dosage.

*WARNING: may be habit forming.

CONTRAINDICATIONS: Infants under 6 months. Acute intermittent porphyria, known hypersensitivity to barbiturates or antihistamines, known previous barbiturate addiction, severe hepatic impairment, CNS injury, senility, and presence of uncontrolled pain.

WARNINGS: Barbiturates may be habit forming. Pre-existing psychologic disturbances may be aggravated. Idiosyncratic reactions may occur. Acquired sensitivity may result in allergic reactions. Safety in pregnancy has not been established.

PRECAUTIONS: Use cautiously with other sedative, hypnotic or narcotic agents. Use with caution in patients with acute or chronic hepatic disease, fever, hyperthyroidism, diabetes mellitus, severe anemia, congestive heart failure, or a history of drug dependence or suicidal tendencies. May impair alertness and coordination with increased accident risk.

ADVERSE REACTIONS: Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory depression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions. Overdose may result in hallucinations, excitement, ataxia, incoordination, athetosis, convulsions, and death.

DOSAGE AND ADMINISTRATION: Rectally, children 2-12 years of age, one WANS® CHILDREN every 6-8 hours as required. Children under 2 years of age may receive ½ the above dosage. *Adults:* Rectally, one WANS® No.1 Supprette™ to inhibit mild nausea and/or vomiting; one WANS® No. 2 Supprette to control pernicious vomiting. Repeat doses for adults should be 4 to 6 hours apart, not to exceed four doses in 24 hours. Moisten finger and Supprette with water before inserting. Optimum dosage must be determined in each case by the clinical response.

WEBCON

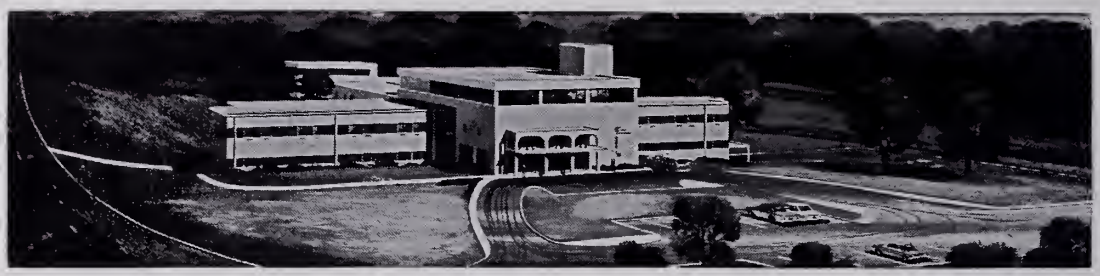
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A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

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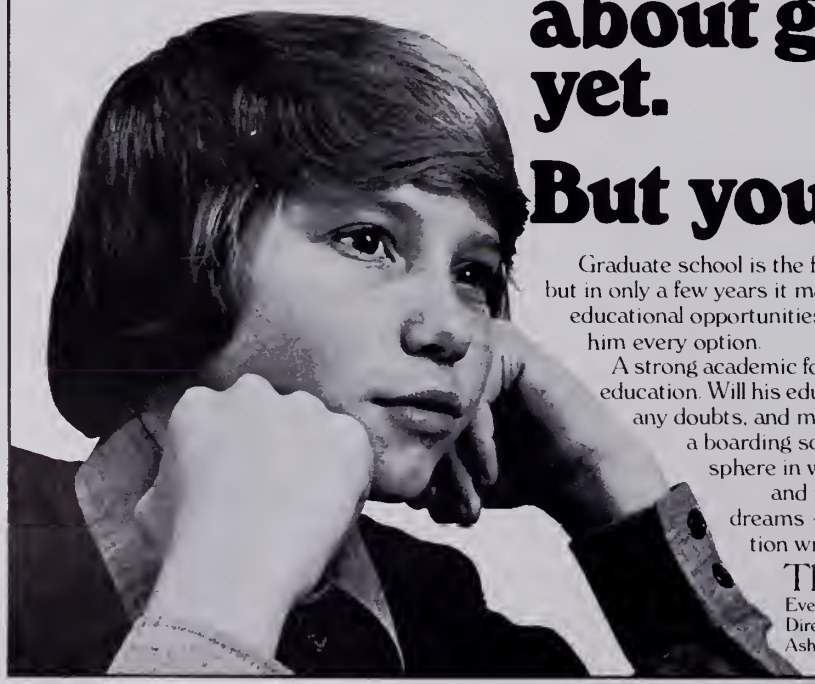
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F. Joseph Nuckols, M.D.
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Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

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Graduate school is the farthest thing from a young boy's mind — but in only a few years it may be uppermost. You should be planning educational opportunities for your son now that will keep open for him every option.

A strong academic foundation is essential to successful higher education. Will his educational needs be met locally? If you have any doubts, and many parents do, we invite you to consider a boarding school. Asheville School provides an atmosphere in which academic excellence is expected — and respected. We can help your son fulfill his dreams — and your dreams for him. For information write:

The Asheville School
Everett F. Gourley
Director of Admissions
Asheville, N. C. 28806

MEETINGS

Approved by FMA Committee on Continuing Medical Education

JANUARY

First Annual Postgraduate Seminar, Ultrasound and Nuclear Medicine, "Interrelated Roles in Medical Diagnosis," Jan. 4-7, Sonesta Beach Hotel and Tennis Club, Key Biscayne*

Seminar in Pediatric Nephrology III: Current Concepts in Diagnosis and Treatment, Jan. 5-8, Americana Hotel, Bal Harbour*

Neuro-Ophthalmology Seminar, Jan. 6-9, Key Biscayne Hotel, Key Biscayne*

Cancer: Diagnosis, Treatment and Prevention, Jan. 7-8, Mt. Sinai Medical Center, Miami Beach

13th Annual Postgraduate Seminar in Anesthesiology, Jan. 9-11, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140.

Shock, Jan. 9-14, Halifax Hospital Medical Center, Daytona Beach. For information: Volusia Academy of Medicine, Clyde Morris Blvd., Daytona Beach 32014

The Role of the Medical Director in the Skilled Nursing Facility, Jan. 10-11, International Hotel, Tampa. For information: Philip H. Gilbert, Dir. Foundation Dept., Florida Medical Association, P.O. Box 2411, Jacksonville 32203.

Virgin Islands Seminar in OB-GYN, Jan. 11-17, Frenchman's Reef, St. Thomas, U.S. Virgin Islands*

Vitreo-Retinal Symposium, Jan. 12-15, Key Biscayne Hotel Key Biscayne*

Miami Winter Symposia, Jan. 12-16, Sheraton Four Ambassadors Hotel, Miami*

10th Annual Postgraduate Seminar in Surgery, Jan. 14-17, Eden Roc Hotel, Miami Beach*

Oral Surgery Seminar, Jan. 15-17, Fontainebleau Hotel, Miami Beach*

Emergency Cardiac Care: 1976, Jan. 15-18, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 1200 N.W. 10th Ave., Miami 33136

Review & Recent Practical Advances in Pathology, Jan. 20-23, Deauville Hotel, Miami Beach*

Infectious Diseases: Treatment and Prevention 1976, Jan. 21-23, Konover House, Miami Beach. For information: Mt. Sinai Medical Center 4300 Alton Rd., Miami Beach 33140

Clinical Topics in Child Neurology, Jan. 21-24, Hyatt House Hotel, Miami Beach*

Pediatric & Adult Urology Postgraduate Seminar, Jan. 21-24, Hyatt House Hotel, Miami Beach*

Cancer Conference: Carcinoma of the Kidney and Renal Pelvis, Jan. 23, St. Joseph's Hospital Auditorium, Tampa For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Current Concepts in Rheumatology, Jan. 23-24, Sonesta Beach Hotel, Key Biscayne. For information: Roy Altman, M.D., V.A. Hospital, Dept. of Medicine, Miami

Anatomic Pathology Workshop, Jan. 23-25, Deauville Hotel, Miami Beach*

Symposium "Frontiers in Diving," Jan. 24-25, J. Hillis Miller Health Center, Gainesville**

Continuing Education in Pediatrics, Jan. 26-29, Diplomat Hotel, Hollywood, Florida. For information: Variety Childrens Hospital, 6125 S.W. 31st St., Miami 33155

11th Annual Postgraduate Course in Internal Medicine 1976, Jan. 26-30, Fontainebleau Hotel, Miami Beach*

Sixth Annual Seminar; Special Procedures in Diagnostic Radiology, Jan. 27-31, Miami*

Course in Hematopathology, Jan. 28-30, VA Hospital, Tampa+

Annual Cardiovascular Seminar, Jan. 30-31, University of South Florida, Tampa+

Twenty-First Central Florida Medical Meeting, Jan. 28-Feb. 1, Orlando. For information: Howard E. Gross, M.D., 15 W. Columbia St., Orlando 32806

▸**Clinical Gastroenterology and Endoscopy,** Jan. 28-Feb. 4, Doral Country Club, Miami. For information: Am. Soc. for Gastrointestinal Endoscopy, Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202.

FEBRUARY

Update Gastroenterology: 1975, Feb. 1-2, Americana Hotel, Miami Beach*

Practical Modern Neurology, Feb. 2-6, Hotel Fontainebleau, Miami Beach*

Practical Problems in Clinical Cardiology, Feb. 2-6, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 2-7, Americana Hotel, Miami Beach*

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

▸ National meetings being held in Florida.

Tenth Annual Symposium on Cosmetic Surgery, Feb. 5-7, Cedars of Lebanon Health Care Center, Miami. For information: Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

Sex Counseling for the Physician, Feb. 5-7, Sheraton Towers, Orlando**

Recent Advances in Cardiopulmonary Care II, Feb. 6-7, Holiday Inn—Lido Beach, Sarasota. For information: Sarasota Memorial Hospital, 1901 Arlington St., Sarasota 33579

Tumors of Infancy and Childhood, Feb. 6-8, All Children's Hospital, St. Petersburg+

Postgraduate Course in Clinical Allergy, Feb. 8-13, Sonesta Beach Hotel, Key Biscayne*

Second Annual USF Cancer Seminar, Feb. 14, Ft. Harrison Hotel, Clearwater+

Symposium in Perinatology, Feb. 18-20, University of Miami School of Medicine, Miami*

Immunological Mechanisms of Disease, Feb. 18-20, Hilton Hotel, Gainesville**

Medical Hypnosis for the Practicing Physician, Feb. 20, Aboard the SS Monarch*

Second Fred J. Woods Lecture Series, Feb. 21, St. Joseph's Hospital, Tampa. For information: Ralph Jensen, M.D., 3001 W. Buffalo Ave., Tampa 33607

Neurology for Psychiatrists, Feb. 23-27, Hotel Fontainebleau, Miami Beach*

"Hematology/Oncology Basic Review and Update," Feb. 26-29, Amelia Island Inn, Amelia Island, Florida. For information: JHEP, 655 West 8th St., Jacksonville 32209.

Workshop—Infectious Disease in Everyday Practice, Feb. 28-Mar. 4, Amelia Island. For information: J. A. Hinckley, P.O. Box 11083, Richmond, Va. 23230

Management of Nonsurgical Medical Emergencies, Feb. 25-27, University of South Florida, Tampa+

Cancer Conference: Diagnosis and Management of Ovarian Carcinoma, Feb. 27, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

▸**Contemporary Surgery,** Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Medicine & Surgery, 30 N. Michigan Ave., Chicago 60602

▸**Contemporary Ophthalmology,** Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Ophthalmology, 30 N. Michigan Ave., Chicago 60602

▸**Contemporary Medicine 1976,** Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Medicine & Surgery, 30 N. Michigan Ave., Chicago 60602

▸**Selected Topics in Cutaneous Medicine,** Feb. 29-Mar. 6, Diplomat Hotel, Hollywood, Florida. For information: N.W. Dermatologic Soc., 1150 David Whitney Bldg., Detroit, Michigan 48226

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Scientific Articles

A Perspective of Acupuncture
Jerome H. Modell, M.D. 123

Home Management of Vomiting and Diarrhea
Warren W. Quillian II, M.D. 129

Special Article

National Health Insurance
VERNON B. ASTLER, M.D. 135

Sections

President's Page
Critique on Today's Scenes: Part 1
MRS. VERNON B. ASTLER 109

Books Received 159

Book Reviews 158

Dean's Page
Continuing Medical Education
E. M. PAPPER, M.D. 116

Deaths 162

Editorials
Caduceus
FRANK G. SLAUGHTER, M.D. 139

The Fifth Pathway
GEORGE H. MCSWAIN, M.D. 141

Further Comments on The Fifth Pathway and Dr. McSwain's Guest Editorial
BERNARD J. FOGEL, M.D. 142

Legislative News
Know These Men
JOHN C. KRUSE, M.D. 120

Letters to the Editor 160

Medical News Around the State 146

Organization
102nd FMA Annual Meeting Preliminary Program ... 147

Thanks to Contributors to Special Issue on Dermatology 157

Others Are Saying
Parapsychology and Medicine
EDWARD PEDRERO JR., M.D. 114

Information

Classified Advertising 167

FMA Officers and Council Chairmen 170

Index to Advertisers 170

Meetings 164

February Cover—Prints of "Caduceus," by Lee Adams are available from the Florida Medical Foundation (See details on page 140). Dr. Frank G. Slaughter, of Jacksonville, explains this month's cover on page 139. Enclosed on page 138a is a miniature of the print available from the Foundation.

President's Page

Critique on Today's Scenes: Part I

Alas, for several months I've been hounding Vern, my husband, to allow me to write a guest editorial (I have?). Well, anyway, I was just beginning to think that Vern was immune to my pleading, threatening and crying, when he finally tossed his scalpel up in despair (broke the blade but didn't dent the ceiling). I interpreted this action as a green light and so now let's "bolt" through some bad American scenes, scenes that I'd like to see rewritten.

The first setting to charge up to—Adult theatres. Now I don't really believe that this is the most important scene to change, it's just that if you were going to stop reading right now, I thought I'd sneak in (not literally) Adult theatre. What I'd like to see changed here is the marquee, for these theatres should be called what they are—Pornographic, not Adult. The term, adult, here implies obscene, dirty, lewd, etc. And as an adult, I resent having this connotation, ditto for the "Adult" book stores.

The economic scene needs to be rewritten. Our inflation could be curtailed if our govenment, the biggest offender and spender, would assume a laissez faire attitude toward businesses and services. For the more the government participates, through subsidies and controls, the more it destroys our Real Market, and instead, it fosters a false market; our government wouldn't have to continue to print more paper money to purchase those goods and services that aren't in demand. Let's return to the old fashioned system of people supplying what people are demanding. With a return to our capitalistic system of supply and demand, the quality of goods and services would improve, and the prices through competitive marketing would be lower.

Another economic scene to change is our income tax system. First of all, a progressive income tax rate is not a part of the 16th amendment. Why can't every U.S. producer pay 20-25% of his gross to the government? This plan would defoliate the jungle IRS. Thousands of agents wouldn't have to be employed with our tax money to investigate how legal our shelters are. Hundreds of millionaires would be paying tax money for the first time. Some people may not think it democratic that a man who grosses $20,000 per year with no dependents pays only $4,000 whereas another man who grosses $20,000 and has seven dependents still pays $4,000 in taxes; however, this man with seven dependents uses seven times more of the public services, e.g., schools, police protection, etc., than the single man.

We need a new script for the school scene. Since we live in a democracy, why can't citizens in each community vote whether or not they want local busing? Why are delinquent and failing students allowed to remain in school? High school principals aren't allowed to expel a student even if he has a cumulative F average. This student (?) is wasting tax money as well as precious space (possibly causing his school to go on a double session). He also has a demoralizing effect on other students and his teachers. Perhaps high schools should have sections, e.g., a college prep, vocational and special education.

A setting that needs elaboration is the election of circuit court Judges. Let's see these incumbent's records in criminal court—their verdicts and sentencing, and then let's hear their challengers platform on crime and punishment.

And doctors, the final scene of the third act relates esoterically to you. How about a better performance from you stars? I have met some of you remarkable men and I know that there is a wealth of brain power in FMA. Some of you have contributed your "Oscar" ideas, but many more of you could get into the act. So, how about jotting down your thoughts or techniques that would be beneficial to your profession and your Association?

I applaud all of you.

Curtain,

Diane Astler (Mrs. Vernon B.)

When women outlive their ovaries...



Advanced osteoporosis revealed by lateral x-ray of spine. Once the cortex has thinned and trabecular bone has been lost, it can never be restored. But once arrested with estrogen replacement, further degenerative change is unlikely.*

"I saw what happened to my mother. It wasn't just how she looked. There was her back, stiff and bent...bladder trouble. I dreaded it."

The realistic, attainable goal of postmenopausal estrogen replacement therapy is to help prevent or delay the serious –often irreversible–effects of estrogen deficiency on estrogen-dependent structures.

There is a growing realization that there is nothing "natural" or "transitory" in the end-organ decline that results from estrogen deprivation; a recognition that a woman "...continues to live while one of her organs –the ovary– dies."[1]

The resulting estrogen deficiency is thought to be an important factor in the pathogenesis of postmenopausal osteoporosis,* and the cause of atrophic changes which may occur in the genitourinary tract, producing such symptoms as atrophic vaginitis and associated dyspareunia, dysuria, and incontinence.

In the woman of menopausal age, "Therapy should be directed toward preventing serious consequences of the menopausal syndrome, which may become irreversible if treatment is withheld too long."[2]

For both prophylaxis and treatment in the menopausal woman, PREMARIN remains the cornerstone in the medical management of estrogen deficiency and its sequelae. For what it can do for her now—and in the future.

*Conjugated Estrogens Tablets have been evaluated as "probably" effective for postmenopausal osteoporosis. See last page of advertisement for prescribing information.

"Some time ago a friend of mine had to have her ovaries removed. And I thought, 'In a few years I might feel just the way she does now.' That wasn't much to look forward to."



For the long-term consequences of the menopause

PREMARIN®
(CONJUGATED ESTROGENS TABLETS, U.S.P.)



CONTAINS NATURAL ESTROGENS EXCLUSIVELY

1. Kupperman, H.S. Med. Aspects Hum. Sexuality 1:64 (Sept.) 1967
2. Sonkin, L.S., and Cohen, E.J. Mod. Treat. 5:545 (May) 1968

See last page of advertisement for prescribing information.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN® Brand of
CONJUGATED ESTROGENS TABLETS, U.S.P.

Actions: Estrogens are responsible for development and maintenance of the female reproductive system and secondary sex characteristics. They cause the growth and development of the vagina, uterus, and fallopian tubes, and enlargement of the breasts. Indirectly, they contribute to the shaping of the skeleton, maintenance of tone and elasticity of urogenital structures, changes in the epiphyses of the long bones that allow for pubertal growth spurt and termination, growth of axillary and pubic hair, and pigmentation of the nipples and genitals. Estrogens are also involved in psychologic and emotional aspects of feminine behavior. As estrogen levels increase during the menstrual cycle, there is a sense of vigor and well-being, and in the menopausal period estrogens aid in relieving nervous symptoms (e.g. anxiety, depression and irritability) due to estrogen deficiency. Decline of estrogenic activity at the end of the menstrual cycle can bring on menstruation, although the cessation of progesterone secretion is the most important factor in the mature ovulatory cycle. However, in the pre- or non-ovulatory cycle, estrogen is the primary determinant in the onset of menstruation. Estrogens do not induce ovulation.

Estrogens affect calcium and phosphorus metabolism, and are involved in maintenance of normal bone structure. In prolonged estrogen deficiency states, administration of estrogen acts to prevent associated bone degenerative changes.

Estrogens appear to be responsible for the relatively greater amount of alpha-lipoprotein and correspondingly lower amount of beta-lipoprotein found in premenopausal women as compared with men.

Estrogens affect the release of pituitary gonadotropins and may also deplete the gonadotropic content of the pituitary.

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed.

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Estrogen usage may cause preexisting fibromyomata to increase in size, therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

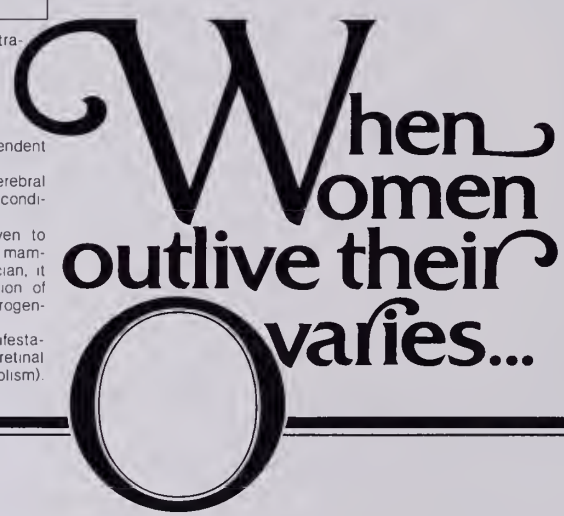
Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)
No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.
No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.
No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.
No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000.

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PREMARIN®
(CONJUGATED ESTROGENS TABLETS, U.S.P.)
contains natural estrogens exclusively

PreSun

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may help prevent harmful effects of the sun such as premature aging of skin and skin cancer.*



*Information on file at Westwood Pharmaceuticals Inc.

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Parapsychology and Medicine

Parapsychology has been defined simply as all mysterious phenomena that cannot be explained by known natural laws. Parapsychologists today are convinced that their work will help solve not only problems connected with the psychic processes but also problems involving the human personality, the meaning of human existence and man's place in the universe.

In 1970 The Academy of Parapsychology and Medicine (APM) was founded by Robert F. Mattson, a computer scientist who stated that the initial purpose was to focus both professional and lay attention on the interdisciplinary research and progress in the realm of paranormal and unorthodox healing practices.

For the past five years the APM has been scheduling symposiums, seminars, workshops and clinics on parapsychology and paranormal healing. The audiences have been substantial and have included many from the medical profession. Biofeedback, acupuncture, psychic diagnosis, bioenergetics, altered states of consciousness, mind-body interaction, the Edgar Cayce readings and the effect of laying on of hands are the most common topics discussed.

Hypnotherapy has been claimed to speed healing from surgical wounds. Cases of advanced cancer have been claimed to have been reversed through a combination of radiology, meditation and mind control. Biofeedback, wherein patients are taught to achieve some degree of control over such normally involuntary functions as heart rate and blood flow, has been claimed to be of value in amelioration of migraine and tension headaches, Raynaud's disease, epilepsy and various other functional organic disorders. A biofeedback research program for the enhancement of the theta rhythm in the electroencephalograph records of research subjects resulted in a considerable increase in the amount of imagery reported.

Clairvoyance diagnosis by a group of talented sensitives were reported 98% accurate under test conditions in personality diagnosis and 80% in physical diagnosis. In studies made with patients at a chronic pain center at LaCrosse, Wisconsin, gifted psychics recorded their evaluations and the results were computerized and cross-correlated with medical records. A LaCrosse, Wisconsin parapsychologist, a Fellow of the American College of Surgeons, reports that about 750,000 special neuroradiological procedures are done each year in the United States while only about 10% demonstrate surgical lesions. He suggests an alternative to the expensive and potentially risky procedures in superspecialization, clairvoyance diagnosis, a parapsychological approach.

Modern parapsychologists believe that man is a multi-dimensional being whose experiences and ultimate purposes are in-extricably and meaningfully related, and that the meaning is made manifest in patterns of health and disease as a directive experience in human development, and that it must be viewed as a manifestation of conditions existing on subtler levels — whether mental, emotional or spiritual.

Parapsychology to most men of science is just a mere collection of strange observations which gets lost in the flood of trashy occult literature. Proof that a healing effect was a parapsychological phenomenon would demand that the patient's recovery occurred under conditions that excluded all influences other than the healer's. We all know how hard it is to fulfill this requirement as healing effects are often only imagined.

Convincing proof of a parapsychological healing effect does not yet exist but modern men of science should not be afraid to travel even though the trail is not yet blazed in parapsychology.

Parapsychic phenomenon should be submitted to systematic research and Extra Sensory Perception (ESP) research should be less theorizing and more practical in the control and application of studied abilities. ESP should be reapproached with less supernaturalism.

Is higher sense perception a kind of super-consciousness activity which may ultimately prove to be a next stop in man's evolutionary development?

Should nontraditional therapeutic modalities be ignored?

Will the devices used in biofeedback be eminently useful in the development of psychoenergetic abilities in humans?

Will there be a time in which man will be recognized as a multidimensional being endowed with the capacity increasingly to shape his experience?

Will the time come when the mind can be trained to be in control of all bodily processes and with this proper perspection will man be consistently healthy?

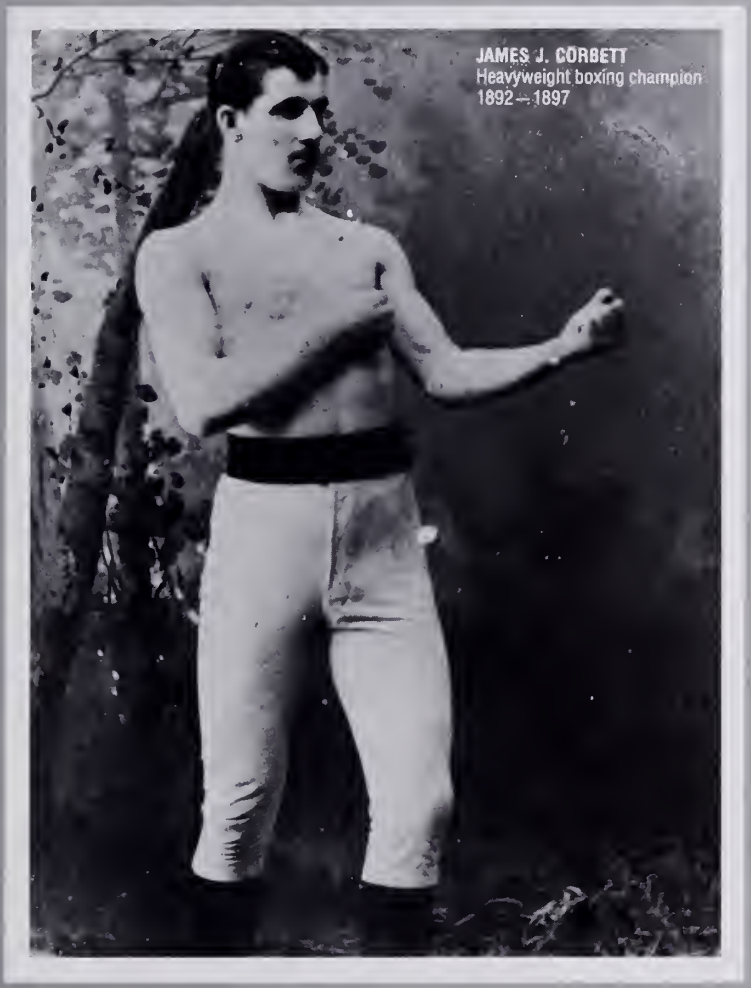
Perhaps spirit and matter are somehow one and that the essential purpose of man is to seek meaning behind all human experience if the true nature of healing is to be found.

One should not forget what Plato said some 2,300 years ago — "if the head and body are to be well, you must begin by curing the soul."

Edward Pedrero, Jr., M.D.
Tampa

Reprinted from The Bulletin of the Hillsborough County Medical Association, January 1976.

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

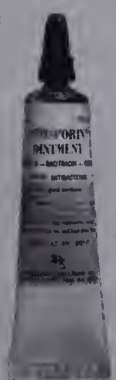
Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains. Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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North Carolina 27709



LUFYLLIN® (dyphylline)

Before prescribing, please review complete product information, a summary of which follows:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Precautions: Exercise caution with use in the presence of severe cardiac disease, renal or hepatic malfunction, glaucoma, hyperthyroidism, peptic ulcer, and concomitant use of other xanthine-containing formulations or other CNS stimulating drugs.

Adverse Reactions: May cause nausea, headache, cardiac palpitation and CNS stimulation. Postprandial administration may help to avoid gastric discomfort.

How Supplied:

LUFYLLIN, 200 mg., Tablets: NDC 19-R521-92, bottle of 100; NDC 19-R521-97, bottle of 1000.

LUFYLLIN Elixir: NDC 19-R515-68, pint bottle; NDC 19-R515-69, gallon bottle.

LUFYLLIN Injection: NDC 19-R537-T2, box of 25 × 2 ml ampuls.

For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

LUFYLLIN®
(dyphylline)

...a basic need for the bronchospastic patient.

Tablets: 200 mg dyphylline
Elixir: per 15 ml: dyphylline 100 mg, alcohol 20% v/v

the bronchodilator with a difference...dyphylline.

A NEED FOR YOUR PATIENT BECAUSE

1. Therapeutically effective
2. Little to no CNS stimulation
3. Little to no gastric upset
4. Effective during long-term therapy
5. Only 1/5 the toxicity of theophylline or aminophylline[1,2,3] (based on animal studies)

REFERENCES

1. McColl, J. D., et al.: **J. Pharm. & Exp. Therap.** 116:343, 1956
2. Quevauviller, Par Andre, et al.: **Presse Med.** 61:1480-1482, 1953
3. Maney, P. V., et al.: **J. Am. Pharm. Assoc** 35:266-272, 1946

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*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Dean's Page

Continuing Medical Education

E. M. Papper, M.D.

The Continuing Medical Education Program of the University of Miami School of Medicine began when the School opened in 1952. South Florida physicians regularly attended grand rounds, teaching conferences, and lectures as well as serving on the voluntary faculty. They were an important component of the Institution's initial teaching faculty.

Prior to 1960 individual departments began to develop specialty Continuing Medical Education seminars and short courses as well as annual lecture series which greatly enhanced the regular teaching program for students, the full time faculty, and physicians in practice in Dade and nearby counties.

The establishment of the Division of Continuing Medical Education in 1970, permitted the School of Medicine to establish accurate records on physician participation in Continuing Medical Education. The first and second annual reports on Continuing Medical Education provide insight into scope and size of the activity as well as the rapid rate of growth that has occurred in this major medical school function.

In 1960-61, four years after the School was founded, we recorded 822 registrations; in 1965-66, 2,610; between 1970-71, 5,925 physicians and allied health professionals; and in the academic year 1974-75, in excess of 12,500 physicians and allied health professionals attended programs sponsored by the University of Miami School of Medicine. These figures do not reflect enrollment in programs which were co-sponsored by the School, nor do they reflect attendance at regularly scheduled teaching conferences, lectures and rounds.

A "head count" means little in and of itself. It is important that we consider the individual components of the total population and equally important to consider the geographic areas we serve. To facilitate our consideration of population components and areas served, it is helpful to separate our educational activities into at least two basic categories: the traditional short courses and seminars and those activities conducted on-site not only in Dade County but in geographic areas remote from the School of Medicine.

To date, the major effort in provision of Continuing Medical Education at the community level has been made through the On-Site Educational Program in Oncology. This activity is conducted by the Comprehensive Cancer Center for the State of Florida at the University of Miami School of Medicine in cooperation with the University of Florida College of Medicine, the University of South Florida College of Medicine and the Florida Division of the American Cancer Society with support from the National Cancer Institute and the U.S. Public Health Service. It provides visits by a team of medical school faculty representing two or three specialties for single lectures, series of lectures, or for visits by a team of medical school faculty representing two or three specialties for a period of one to three days. During a nine months period in the 1974-75 academic year, the On-Site Educational Program in Oncology provided educational opportunities to 6,145 physicians and allied health professionals—just slightly less than 50% of our total enrollment for the year. The oncology program is only one example of the many programs offered to physicians, nurses and the public by the faculty.

The traditional short courses and seminars are for the most part held either at the School of Medicine or at local hotels.

Enrollment of 4,058 health science professionals from almost all the 50 United States plus 218 from around the world demonstrates the universality of our educational program. It is gratifying to note that the University of Miami School of Medicine serves as the educational resource for large numbers of the health professionals residing in Florida; in excess of 2,100 Florida physicians registrants attended these seminars bringing the Florida enrollment to 66% of the total.

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

In this brief note I have dealt primarily with numbers. In subsequent reports I would like to describe in detail the content of the general and specialty programs offered by the School of Medicine and to share with you our goals for the future. We are acutely aware of the pressure being exerted on the medical community at large; we recognize the responsibility of the academic community in the area of Continuing Medical Education. We believe the School of Medicine and practicing physicians must define their educational objectives and develop a system for provision of a quality program in Continuing Medical Education.

Dr. Papper, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

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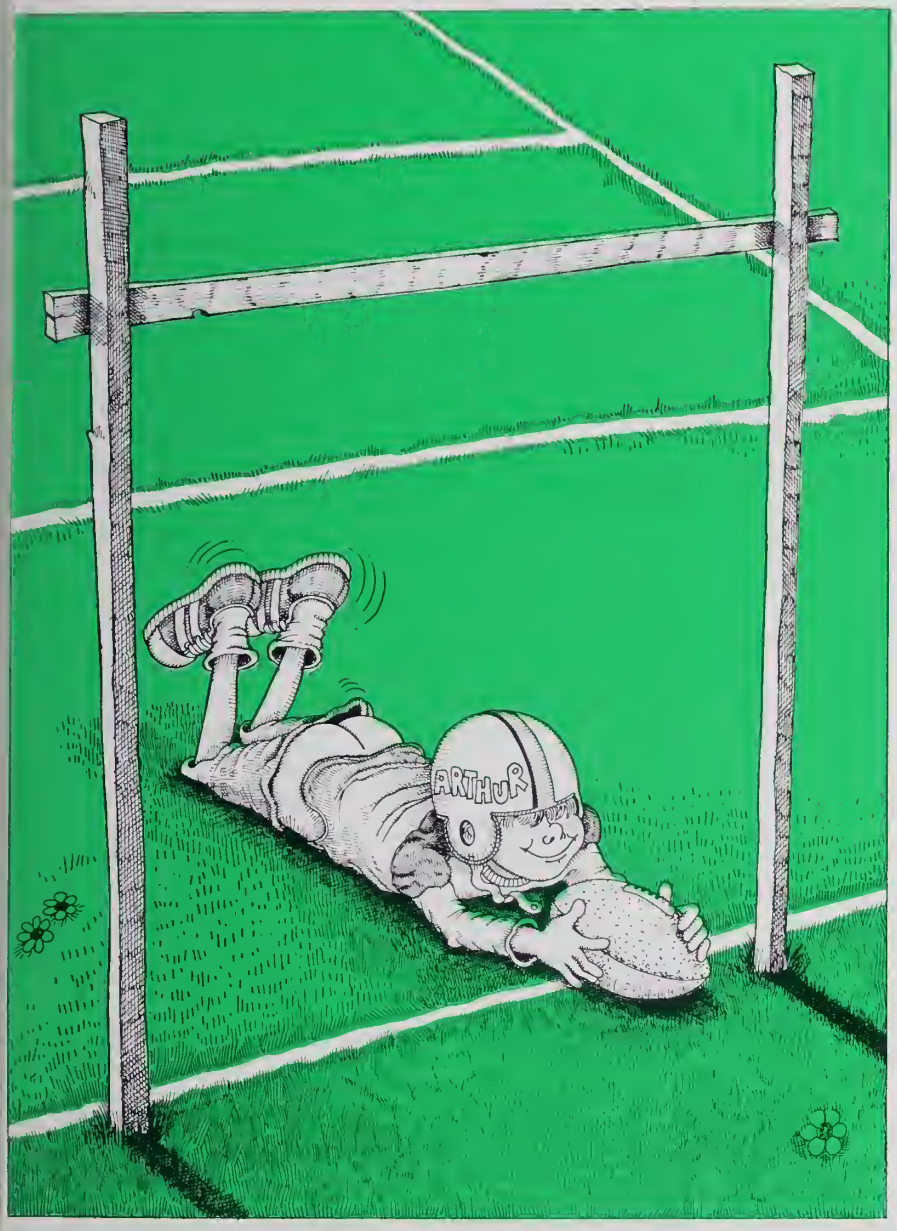
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LEGISLATIVE NEWS

Know These Men

As outlined in last month's Legislative News, the focal point of the legislative effort is the committee. The key to success in any legislative effort is to do all the necessary groundwork with the members of the committee to which the legislation you wish passed is assigned. If a bill passes by a heavily favorable vote in committee, and can be placed on the calendar, its chances for success are very good. Equally crucial in this effort is to get an early public hearing and vote.

Since this effort is so important, the content of this month's Legislative News is a list of the key committee members and their key contact physicians (key contact physicians in parenthesis). Any member who has personal friendship or knowledge of these legislators is urged to contact the FMA Tallahassee office immediately so that you can be brought up-to-date and kept current with the FMA's legislative efforts.

In the House, the Chairman of the Committee on Health and Rehabilitative Services is Barry Kutun of Miami (J. Groff). Walter W. Sackett, M.D. of Miami is Vice Chairman. Members are: Edmond M. Fortune (D), Pace (E. W. Sutton); S. P. Bell (D), Daytona Beach (J. G. White); Elaine Gordon (D), Miami (R. Cohen); David J. Lehman, M.D. (D), Fort Lauderdale; Sidney Martin (D), Hawthorne (G. T. Singleton); Robert W. McKnight (D), Miami (D. H. Altman); George H. Sheldon (D), Tampa (L. E. Cimino and S. G. Hibbs); Walter C. Young (D), Hollywood (W. Dickens); Larry Belanger (R), St. Petersburg (W. F. Mallette); Don F. Hazelton (R), West Palm Beach (B. Kimmel and B. F. O'Hara); Dennis McDonald (R), St. Petersburg (D. I. MacDonald); Eric Smith (D), Jacksonville (S. A. Mullen); James H. Thompson (D), Quincy (P. Woodward); G. H. Crabtree (R), Sarasota (R. E. Windom); R. H. Langley (R), Clermont (D. R. Lehrer); H. Paul Nuckolls (R), New Port Richey (H. D. Williams), and G. A. Williamson (R), Fort Lauderdale (W. Dickens).

The Speaker of the House is Donald L. Tucker (D), Tallahassee (L. L. Pararo). In the Senate, the Committee on Health and Rehabilitative Services is chaired by D. Robert Graham (D), Miami Lakes (J. C. Hirschman). Vice Chairman is John Vogt (D), Cocoa Beach (A. I. Decker and J. F. Carter). Members are: Don C. Childers (D), West Palm Beach (D. L. Van Eldik); Jack D. Gordon (D), Miami Beach (R. R. Rosenblum); Walter Sims (R), Orlando (R. M. Holloway); James A. Glisson (R), Tavares; Jon C. Thomas (R), Fort Lauderdale (David H. Holt), and David C. Lane, M.D. (R), Fort Lauderdale.

COMMERCE: Members are W. D. Childers (D), Chairman, Pensacola (Andrew Giesen and W. H. Nass); Sherman S. Winn (D), Vice Chairman, Miami (J. Allison and J. Groff); Tom Gallen (D), Bradenton (J. D. Lehman); Pat Thomas (D), Tallahassee (C. Curry); Lew Brantley (D), Jacksonville (S. A. Mullen and J. W. Walker); Alan Trask (D), Fort Meade (T. M. Caswell); John T. Ware (R), St. Petersburg (J. M. Hamilton); Kenneth A. Plante (R), Winter Park (E. W. Stoner and G. Brock Magruder), and Warren S. Henderson (R), Sarasota (S. O. Sager).

JUDICIARY (Civil): Members are Tom Gallen (D), Chairman, Bradenton (J. D. Lehman); Jane W. Robinson (R), Cocoa; Sherrill "Pete" Skinner (D), Lake City, and George Williamson (R), Fort Lauderdale (W. Dickens).

HOUSE COMMERCE COMMITTEE: Members are John R. Forbes (D), Chairman, Jacksonville (J. C. Kruse); Paul B. Steinberg (D), Miami Beach (M. P. Travers); Karen B. Coolman (D), Fort Lauderdale (L. G. Appell); Ralph H. Haben (D), Palmetto (W. E. Wenzel); Nancy O. Harrington (D), Coral Gables (R. G. Gilbert); E. J. Healy (D), West Palm Beach (D. L. Van Eldik); John A. Hill (D), Miami Lakes (C. W. Hoffman); John W. Lewis (D), Jacksonville (S. J. Alford); W. H. Lockward (D), Hialeah (A. S.

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The President of the Senate is Dempsey J. Barron (D), Panama City (B. P. Cotton, Dixon R. McCloy and Joseph Hendrix).

A reminder to ourselves about discipline: One of the sections of the Malpractice Reform Act of 1975 mandates that any disciplinary action taken by a county medical society or a hospital board or medical staff be reported to the Board of Medical Examiners within 30 days of such action. Failure to report such action can result in a $500 fine. No liability action can be taken against the medical society or hospital board or staff as a result of communicating these actions to the Board of Medical Examiners. Further, medical staffs of licensed hospitals are authorized to discipline a staff member for incompetence, negligence, being an habitual user of alcohol or drugs, or being found liable by a court for medical malpractice. If the procedures for such action comply with standards laid down by the JCAH and the Principles of Participation in the Federal Health Insurance Program for the Aged, "there shall be no liability or cause of action against the hospital medical staff or disciplinary body if such actions were taken in good faith and without malice" (Sec. 13, Malpractice Reform Act of 1975).

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A Perspective of Acupuncture

Acupuncture, and how it has, or should, relate to Western medicine is a continuing challenge to Florida physicians. At the request of the Editor, Dr. Jerome H. Modell has prepared this review article "A Perspective of Acupuncture" to compendiate the present information on this topic.

Dr. Modell was a member of the team of scientists who, as guests of the Chinese Medical Association, comprised the "Acupuncture Anesthesia Study Group of the Committee on Scholarly Communication With the People's Republic of China" in May 1974.

The Editors of the Journal are most grateful to Dr. Modell for this scholarly contribution.—The Editor.

Jerome H. Modell, M.D.

Abstract: Observations during a visit to the People's Republic of China suggest that acupuncture is used to treat patients with self-limiting diseases, those for whom no effective Western therapy exists, or those with pain who have not responded adequately to Western therapy. Frequently acupuncture was combined with other medications; it was not possible to determine whether the same results would have been obtained with either acupuncture or medication alone. Presently the role of acupuncture treatment in the United States appears to be limited to patients with chronic pain who respond inadequately to Western therapy. A small number of such patients have obtained long-lasting relief with acupuncture. Observations on "acupuncture anesthesia" in both the People's Republic of China and the United States suggest it is still a highly experimental procedure whose success is heavily dependent on patient motivation.

The technique of acupuncture, or needling the body, has been used in China for over 2,000 years. "Acupuncture" by itself is not considered a healing art but rather one of the modalities associated with traditional Chinese medicine. Sometimes it is used as the sole therapy for patients but more frequently it is combined with other medications classified as traditional Chinese medicines. Some are similar to those used in the practice of Western medicine for similar diseases. While traditional Chinese medicine has been practiced for centuries, it periodically has fallen into disrepute. It was not until Chairman Mao Tse Tung established the current government of the People's Republic of China (PRC) that traditional Chinese medicine regained an acceptable status. Chairman Mao has taught that "traditional Chinese medicine is a great treasure house, and it should be combined with Western medicine to elevate it to new heights." In so doing, traditional Chinese doctors and Western-trained doctors frequently work side-by-side in some of the hospitals in the People's Republic of China, thus learning from each other and combining techniques. From a visit that I made as a member of the Acupuncture Anesthesia Study Group of the Committee on Scholarly Communication with the People's Republic of China in May 1974,[1] I received various impressions presented here regarding the current status of traditional Chinese medicine and therapy with acupuncture.

Approximately 800 million people live in the People's Republic of China. Yet, the number of physicians trained to practice medicine, as we know it, i.e., Western medicine, is perhaps insufficient to care for even 200 million people. The exact numbers are unknown because it seemed that such statistics are not kept in the People's Republic of China. We could not obtain an accurate Census Report on either the number of people living in the country nor on the number of physicians. Since there was an insufficient number of physicians to care for the patients, and since a number of people had been trained in traditional Chinese medicine but up to this time had not achieved the same stature as Western doctors, it seems reasonable that the Health Delivery Task Force would be increased tremendously if those practicing traditional Chinese medicine

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were to be afforded an acceptable status. To me, this may have been one of the leading motivations in reestablishing traditional Chinese medicine as an accepted method of practice. I view the combining of traditional Chinese medicine with Western medicine as an expedient means of reeducating those trained in traditional medicine to some of the methodology essential to proper diagnosis and therapy as we know it. One could look upon this training as being similar to a postgraduate course, apprenticeship, or unofficial residency training.

The two systems of practice plus the "barefoot doctor" establish a triage system. The "barefoot doctor" is not a doctor in either the sense of traditional Chinese medicine or Western medicine, but rather he is trained for three to 12 months to screen patients and to treat them for minor illnesses in the commune, factory or similar location. These members of the health care team reminded me of senior hospital corpsmen in the Armed Forces, and perhaps could be equated with some of the recently developed Physicians' Assistants Programs. We visited a variety of hospitals, ranging from the hospital at a commune to the major teaching hospitals in the large cities. From the responses to our questions regarding the types of illnesses treated in the various hospitals, there clearly is a triage system from the commune hospitals to the county hospitals to the city hospitals and then to the Western medical school centers. Patients are transferred up the system as required to treat their illness. It seems to be a system of complete cooperation and there does not appear to be competition between hospitals or feelings of failure if one has to transfer the patient for further therapy. Each person in the health care delivery team appears to be well respected by the others and status symbols are essentially nonexistent.

Physicians in the larger hospitals periodically (approximately every five years) move to county hospitals or to communes for reeducation as to the needs of the people. During this reeducation period (approximately six months), the physician may work side-by-side in the field with the peasants or in the factories with the workers. In addition he or she participates in the health care of the peasants and workers and, thereby, works side-by-side with the doctors in the smaller hospitals, exposing them to some of the newer techniques used in the major teaching centers. Thus, the physicians from the large city hospitals are reeducated as to the needs of the people, and the "barefoot doctors," the traditional Chinese doctors, and the Western doctors serving the people in their own localities receive a "refresher course" in their own hospital environment.

Although there are currently two types of medical schools in the People's Republic of China, those teaching traditional Chinese medicine and those teaching Western medicine, we were told in Kuanchou that they are to be combined, and our host predicted that in the not too distant future there would be only one type of medical school, the Western medical school which would teach some courses in traditional Chinese medicine.

Prior to visiting the People's Republic of China I had the impression from reading American newspaper accounts of previous visitors that acupuncture was used to treat almost any disease, including infections, carcinoma, and metabolic diseases. In the PRC I saw no evidence to support such statements. For example, when we visited a College for Traditional Chinese Medicine in Peking, I asked whether they used acupuncture to treat cancer. I was told, "no." Cancer is treated either with chemotherapeutic agents or with surgery. However, once the maximum therapy had been administered and if the patient had residual pain which responded poorly to analgesic agents, then it was likely that he would be administered acupuncture to help reduce the pain. In observing a number of patients treated with acupuncture in clinics of various hospitals, it became apparent that acupuncture is used to treat patients with self-limiting diseases, to treat diseases for which there is no good Western therapy, or to treat patients with pain problems that have not responded well to Western therapy.

Frequently acupuncture was combined with medication. In most cases the medications were traditional Chinese medicines, but sometimes they resembled the type of therapy a patient would receive in a Western country. Some examples to support this statement follow. Figure 1 shows a patient who had suffered a stroke approximately 12 months earlier; he originally had hemiparesis. With the acupuncture therapy, the patient was encouraged to use his affected side. At first members of the health care team manipulated his arm and leg for him, and as time passed and his strength improved he was able to manipulate them himself. Thus, every time this patient received electroacupuncture therapy, he also received a form of physical therapy. In the same clinic we saw a young lady who suffers from a neurosis which is not severe enough to prevent her from working. She received electroacupuncture five days a week for approximately 30 minutes. During this time an attendant (who appeared to be either a physician or a nurse) was constantly

talking with her regarding her problems. Thus, it appeared that the acupuncture therapy was combined with a form of psychotherapy.

Figure 2 is of a young lady with Bell's palsy who was being treated with moxibustion. We were told that most patients who have Bell's palsy are treated for approximately four weeks with either acupuncture or moxibustion. Uncomplicated Bell's palsy is thought to be a self-limiting disease which runs its course in approximately four to six weeks. Figure 3 is of a patient with Parkinson's disease whose tremor was so severe that she was unable to peel fruits and vegetables to cook for her family. She was receiving traditional medications and manual acupuncture. During the acupuncture therapy she constantly worked with her hands peeling fruits and vegetables to help increase her coordination.

Figure 4 is an 11-year-old patient with strabismus. Strabismus is treated with acupuncture, reading exercises, and corrective glasses when appropriate. Surgery for strabismus is not performed until patients reach their teens, and then those patients who did not respond to conservative therapy undergo surgical correction of the eye muscles.

Figure 5 is a patient being treated for peptic ulcer. After hearing a presentation comparing the use of acupuncture in the treatment of peptic ulcers with the treatment of Western medicine in a controlled series in the same hospital, we visited the clinic. During the presentation we learned that the results of either type of therapy were almost identical. Upon interviewing the patient seen in Figure 5, we learned that he received acupuncture therapy five days a week for five weeks. The patient, upon questioning, said that although he was not told exactly what he could eat, he was told to avoid spicy foods and to eat frequently but in small amounts. While he did not receive any Western medicines, he was taking three traditional Chinese medicines: ground pearl (calcium), tincture of licorice (an antispasmodic), and glycerin. The patient did not work during the five-week therapy but nevertheless received his wages. During his 30-minute acupuncture treatment, someone was in attendance to talk with him. I could not separate what role the acupuncture played. This patient was removed from the possible stress of his job, his diet was altered, he was taking medications which had antispasmodic and coating effects, and he was able to discuss his problems with someone five days a week for five weeks. It was my impression that this differed only slightly from the manner in which a patient with a peptic ulcer might be treated conservatively in the United States.



Fig. 1.—This patient is receiving electroacupuncture as therapy for a cerebrovascular accident suffered approximately one year previously.



Fig. 2.—This patient is receiving moxibustion as therapy for Bell's palsy.

One area where acupuncture by itself appeared to be effective in at least some patients was in the treatment of chronic pain. The most common problems being treated were the pain of arthritis and low back pain, but certainly the use of acupuncture was not limited to these. Virtually every patient we questioned reported that he felt better after the acupuncture treatment. However, we saw no objective or subjective quantitation of the degree of pain relief. We also were unable to elicit any statistics on the incidence of pain relief since such statistics apparently are not kept in the PRC. The impression received was that acupuncture works to relieve pain, for it has been used for over 2,000



Fig. 3.—This patient is receiving manual acupuncture as therapy for Parkinson's disease.



Fig. 4.—This patient is receiving a form of acupuncture therapy for strabismus.

years for this purpose; therefore, it is not important to keep statistics at this time. We were unable to determine the duration of pain relief however, most of the patients who were interviewed had had acupuncture previously, suggesting that pain relief is not permanent.

These observations seem consistent with what we have found in studies at the University of Florida. In a group of 261 patients who had chronic pain from a variety of causes and who had already received the benefit of Western therapy, 28% reported at least 75% relief of pain after the first acupuncture treatment. The incidence of successful therapy increased with subsequent treatments in this study. Four treatments were given on consecutive days. By the end of the fourth day, 54% of patients reported at least 75% relief of pain. It is interesting that after four weeks only 18% of these patients still reported greater than 75% relief of pain, thus suggesting that pain relief after acupuncture, at least for the majority of patients, is temporary.[2] Follow-up of these patients and expansion of the study to include 533 patients showed similar results. In addition, three months after therapy 12% of the patients still had significant pain relief.[3] It seems at least some patients do receive significant pain relief from acupuncture therapy; however, in the majority the pain returns.

Traditional Chinese medicine has taught that the use of acupuncture affects the balance of flow of energy through the body, the concept of Yin and Yang. It would appear logical, then, that the acupuncture needles be placed in the exact acupuncture points to produce the desired effect. This is not the case, however, since in our study we found identical results whether needles were placed in traditional Chinese meridians or in arbitrary control points.[2]

When we observed various surgical procedures performed with acupuncture in the PRC, the same procedure was performed using different needle placements on every patient. When we asked about needle placement we were told that "acupuncture anesthesia" is an experimental procedure and they were still looking for the best points.[1] A histologist researching "acupuncture anesthesia" informed us that a surgeon in Peking gave the needle to the patient and let the patient insert it wherever he wished and his results were as successful as when the physician selected the needling point. These observations suggest that the concept of balancing the flow of energy is not valid in the use of acupuncture either in an attempt to produce pain relief from chronic disease or from a surgical incision.

Experiments have been performed in the PRC demonstrating an increase in pain threshold of patients who are receiving acupuncture therapy.[5] A major criticism of this experimentation, however, is that there is no double-blind control. The patients know when they are receiving acupuncture and when they are not. It is also possible that they are anticipating the result, thus producing the positive findings. Extensive research is being performed in the PRC in an attempt to establish a physiologic mechanism for "acupuncture anesthesia." Although numerous scientists are attempting to locate areas within the central nervous system that acupuncture affects, to date no definitive, noncontroversial find-



Fig. 5.—This patient is being treated with electroacupuncture for peptic ulcer.

ings have emerged. The evidence in some experiments suggests that the acupuncture effect is through the nervous system rather than being blood born.[6] On the other hand, cross-circulation experiments in experimental animals also have suggested an increase in pain threshold with acupuncture.[7] These observations could be in conflict.

A consistent finding, however, is that if the acupuncture points are pretreated with an injection of local anesthesia, then the acupuncture effect is not seen.[6] It appears that the patient must perceive the stimulus of needling.[5] Is it not possible, therefore, that if the patient focuses on the acupuncture stimulus, he is more likely to block out other stimuli? We know that when there are conflicting stimuli, some are not registered at the conscious level. Examples include Beecher's[8] observations on wounded soldiers who did not feel pain until they were removed from the battlefield and admitted to the hospital, dentists' use of "white sound" to increase pain threshold,[9] and athletes who may be injured during a competitive match but are not aware of their injury until the match is completed.[10] Is it not also possible, therefore, that the patient focuses on the acupuncture stimulus and this focus blocks out his ability to perceive and interpret other stimuli. Thus, as long as the patient is able to focus on the acupuncture stimulus, the area that previously was emitting stimuli being interpreted as pain by the patient would not be perceived as such. It is only when the patient no longer can focus on the acupuncture stimulus, either actively or retrospectively, that the pain sensation would return. Such an explanation could be compatible with either a psychological or a physiological effect. The former is easy to perceive, the latter could occur if one could demonstrate that when two stimuli are present only one or neither reach the brain for interpretation.

"Acupuncture anesthesia" has received considerable attention since former President Nixon's visit to the PRC in 1972. It is true that large numbers of patients in the People's Republic of China have been operated upon without the use of conventional anesthetics, but with a substitution of acupuncture. I have observed a number of these patients. The most impressive was a 22-year-old woman who underwent repair of a ventricular septal defect with cardiopulmonary bypass. The patient received preoperative medication of 100 mg. of phenobarbital and 50 mg. of meperidine. Otherwise the entire procedure was performed with electroacupuncture stimulation. The patient never reported a feeling of pain, and had reasonably stable vital signs throughout the procedure (Figs. 6 and 7). On the other hand, I also witnessed some outstanding failures as evidenced by a patient (Fig. 8) who displayed his displeasure when they made a neck incision. This same patient had surgery on his lip performed successfully under acupuncture previously. In the patients we observed there was no relationship between the apparent complexity of the surgical procedure and the degree of success. It appears that the technique of "acupuncture anesthesia" is highly experimental, and early results suggest that it has limited, if any, use in current medical practice.[11]



Fig. 6.—This 22-year-old woman is undergoing open-heart surgery for a ventricular septal defect under electroacupuncture anesthesia.

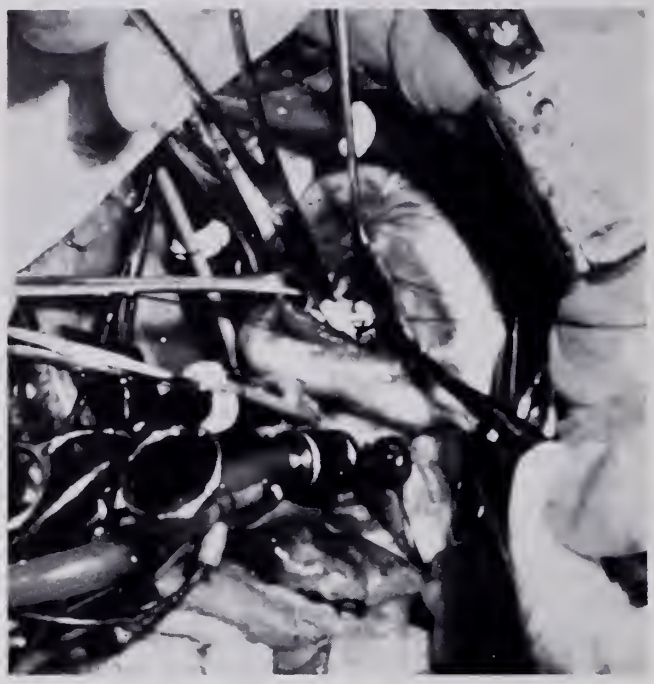


Fig. 7.—Closure of the ventricular septal defect has been accomplished. The patch is shown in place. The patient is on cardiopulmonary bypass.



Fig. 8.—This patient is shown as a skin incision is made to perform a radical neck dissection.

The question now must be answered as to whether acupuncture therapy has a role in modern medicine in the United States. I believe that there is sufficient evidence to suggest that it should not be used as primary therapy for any active disease. Active disease processes should be properly diagnosed and treated with specific medical or surgical therapy as indicated. There is no scientific evidence to document "miraculous cures" by acupuncture. On the other hand, patients who are suffering from chronic pain and who have received proper diagnosis and therapy without sufficient success may be candidates for an attempt at acupuncture therapy. When acupuncture therapy is used, both physician and patient must be realistic in what they might expect. The incidence of prolonged pain relief is not inconsistent with the incidence of success with placebos. On the other hand, some patients report a relaxed soothing feeling during electroacupuncture which suggests that if their chronic pain is from muscle spasm, focusing on the acupuncture effect may indeed relax or relieve this spasm at least temporarily, thus breaking the pain cycle. The complications of acupuncture therapy appear to be those due to poor technique, i.e., puncture of vital structures and infection. Then, if the acupuncture is performed by one who is cognizant of modern aseptic techniques and anatomy, there is little likelihood of doing permanent injury to the patient and a try at acupuncture for patients with chronic pain who respond poorly to other therapy may be indicated.

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References

1. Report of Acupuncture Anesthesia Study Group. Acupuncture Hypalgesia in Surgical Procedures. An Appraisal of Its Use in the People's Republic of China. Submitted for publication.
2. Lee, P. K.; Andersen, T. W., and Modell, J. H., et al: Treatment of Chronic Pain with Acupuncture, JAMA 232:1133-1135, 1975.
3. Lee, P. K.; Modell, J. H., and Andersen, T. W., et al: Incidence of Prolonged Pain Relief Following Acupuncture, Anesth. Analg. In Press.
4. Modell, J. H.: Observations of "Acupuncture Anesthesia" in the People's Republic of China (Editorial), Arch. Surg. 109:731-733, 1974.
5. Research Group of Acupuncture Anesthesia, Peking Medical College: Effect of Acupuncture on Pain Threshold of Human Skin, Chin. Med. J. 3:161-167, 1973, English Abstract, p. 35.
6. Chiang, C. Y.; Chang, C. T., and Chu, H. L., et al: Peripheral Afferent Pathway for Acupuncture Analgesia, Scientia Sin. 16:210-217, 1973.
7. Shanghai Acupuncture Anesthesia Coordinating Group: Acupuncture Anaesthesia. An Anaesthetic Method by Combination of Traditional Chinese and Western Medicine, Aug. 1973.
8. Beecher, H. K.: Resuscitation and Anesthesia for Wounded Men, Springfield, Charles C. Thomas, 1949, pp. 15-17.
9. Gardner, W. J., and Licklider, J. C.: Auditory Analgesia in Dental Operations, J. Am. Dent. Assoc. 59:1144-1149, 1959.
10. Allen, W.: Personal Communication.
11. Modell, J. H.; Lee, P. K., and Bingham, H. G., et al: "Acupuncture Anesthesia"—A Pilot Study. Submitted.

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Home Management of Vomiting and Diarrhea

Warren W. Quillian II, M.D.

Abstract: Certain aspects of the pathophysiology of acute gastroenteritis are discussed. Early outpatient treatment stresses both the type of oral fluid and the mode of its administration. A table depicting the electrolyte components of commonly used beverages is included. Prevention of problems is the key of successful management.

Vomiting and diarrhea may be defined as an excess of fluid and electrolyte loss from either the upper or lower alimentary tract. The pathophysiology of such losses are different; therefore, different principles in oral therapy must be considered. This paper reviews various mechanisms involved in gastrointestinal fluid and salt loss and emphasizes proper selection of oral fluids, mode of administration and consideration of drugs in combating infant and childhood gastroenteritis on an outpatient basis. Prevention of problems is the key to keeping these youngsters out of the hospital.

Pathophysiology

The intestine is a complex organ handling many nutrients. Water and electrolyte absorption and secretion are interdependent with each other and with certain transport systems. Indeed, a problem with any one system can lead to a cascade of events that results in excessive fluid and salt losses. The type and amount of these losses are most important.

Water is absorbed along the entire intestinal tract, the greatest amount by the small intestine. Only 20% of the absorbed fluid comes from external sources. The remainder originates from internal secretion and cellular debris. Water is absorbed primarily in a passive manner, but it depends to a great extent on the active transport of solutes (i.e., sodium), osmotic gradients and hydrostatic pressure across the intestinal epithelium.[1] The movement of any volume of secretion or absorption is not a one way phenomenon but rather a net result of a dynamic bidirectional flux. Water and ions wash back and forth between the gut lumen and blood through intercellular spaces and across mucosal cells. Active transport systems (i.e., glucose) in the gut epithelium, permeability of the mucosa, osmolality of the intraluminal fluid, motility, blood and nerve supply, as well as hormonal and chemical factors all influence water absorption.[2] Disruption of any of these may lead to diarrhea.

When disease interferes with small intestinal function, the colon becomes an important site of fluid absorption. The distal colon reabsorbs water via a cellular sodium pump mechanism.[3] If there is a damaged colon, then there is less electrolyte reabsorption and the usual stool concentration can increase almost in geometric progression.[4] Associated with this increase in intraluminal tonicity is a parallel increase in water loss which may vary from 10 to 60 cc/kg of body weight.

Other fluid losses occur in the small bowel by an osmotic effect caused by intraluminal sugar.[2] Disaccharides such as lactose are actively absorbed after being broken down by enzymes (disaccharidases) in the brush border of the small intestine. If bowel injury occurs at the level of these active transport systems, the result is increased intraluminal osmotic concentration of the sugar, thereby causing further fluid shifts into the gut. If a large amount of disaccharides is undigested and dumped into the large colon, a fermentation process develops with the help of coliform bacteria. The result is an acidic diarrhea.

Sugars are absorbed either actively or passively.[1] Glucose and galactose exert active up-stream transport from the gut lumen to the blood. With this transport, there is an expenditure of energy and a certain amount of water is "dragged" into circulation with the sugar. Passive diffusion of monosaccharides is less important.

Gastrointestinal electrolyte loss is quite variable.[5] This depends upon a number of things including type and amount of oral intake, transudation of

extracellular fluid, transit time, reabsorption of water and electrolyte, together with controlling neural and hormonal factors. There is no apparent correlation between stool sodium content and serum sodium values. The extracellular concentration of sodium is also affected by other variables such as insensible water loss and failure of appropriate renal conservation. The variation in these sodium losses is reflected in the patient's serum electrolyte picture. If there is a proportional water and electrolyte loss, the deficit is probably in the range of 7-11 mEq/kg of sodium. This results in isotonic dehydration. With sodium losses out of proportion to water the deficit is 10-14 mEq/kg and the result is hypotonic dehydration. A disproportionately large net water loss over electrolytes (deficit of sodium of approximately 2-5 mEq/kg) may result in a hypertonic problem.[6,18]

The amount of specific electrolyte loss and the body's attempt at compensation through renal and respiratory mechanisms result in certain clinical pictures. For example, with extreme upper gastrointestinal electrolyte loss, the patient may present with hypochloremic, hypokalemic metabolic alkalosis. Lower tract losses (i.e., HCO_3) often result in metabolic acidosis. These problems may be obviated by early recognition of the problem, adherence to certain principles of therapy and careful selection of oral fluids.

Clinical symptoms and signs can be correlated with various stages of gastrointestinal disturbance.[1] A simplified explanation follows. When the proximal stomach is dilated like an atonic bag, the patient may experience the feeling of anorexia. With the addition of duodenal spasm, he becomes nauseated. If then, reverse peristalsis occurs in association with a central neuromuscular reflex, the result is vomiting. Small bowel irritation may cause myenteric plexus stimulation and subsequent increased conventional peristalsis may result in cramping. Such neurogenic reflex activity is important in gut motility. If there is an increase in transit time and/or excess fluid and electrolyte loss in the feces, then diarrhea occurs.

It is not the purpose of this paper to discuss the multitude of etiologic agents causing bowel upset. There are many irritants from without and within the gastrointestinal tract including inflammatory lesions (bacterial, ?viral, toxins), allergy, metabolic disorders, mechanical problems, and parenteral infections. In pediatrics, the vast majority of causes of gastroenteritis is presumed to be viral in origin, although controlled studies have had difficulty in proving this assumption.

Treatment

The first item in the ideal management of a youngster with gastroenteritis is an accurate diagnosis based upon a good history and careful physical examination. The amount of fluid and electrolyte losses is affected by the duration of the illness, patient's size and general condition, and type of oral intake. Body weight variations, skin turgor, and the clinical picture should define the magnitude of the problem. If the patient is less than 3% dehydrated, then a trial of oral fluids is indicated.

Much of our care of patients with dehydration is based on the body's "wisdom" of handling the solutions we offer it. The body's homeostasis is thereby maintained by the integral physiologic relationships of the respiratory, renal and buffering systems.

The objective of oral fluid therapy for the treatment of mild gastroenteritis is to replace adequately caloric, water and electrolyte deficits without increasing these losses through stooling or continued vomiting. Solutions used to accomplish this should be accepted readily and balanced to avoid accentuation of hypotonic or hypertonic conditions.

Knowledge of the electrolyte content of the common liquids (Table 1) in the individual physician's own locale is essential for the proper evaluation and treatment of gastrointestinal fluid losses.[8,9] Many different beverages may be used at home. The mineral content varies and is a reflection of both the local water supply and the manufacturer's individual taste. Ingestion of fluids that are excessively hypotonic might contribute to unfortunate complications. For example, Kool-Aid is palatable and readily accepted by infants, yet it has virtually no electrolyte content. Some of the more concentrated solutions (i.e., tomato juice) are not universally accepted by children and bouillon with a high salt content may be dangerous if taken freely by a small child. The expensive commercial oral electrolyte solutions are, by and large, well formulated for older children but they are potentially harmful for small infants. Pow-

Table I. — Composition of Fluids Frequently Used in Dehydration (Dade County, Florida).

	Na.	K.	Cl.	Cal.	Cho.	Cost ($)
	mEq./L			L.	gm./L.	L.
Jell-O Water	12	0.15	2	330	75	.25
Coca-Cola	3.6	0.15		435	109	.35
Kool-Aid	1.7	0.06	1	7.5	1.6	.10
Orange Juice	3	25-49		444	104	.35
Bouillon	168	1.4	158	4		.10
Lytren	25	25	30	280	70	1.80
Pedialyte	30	20	30	203	50	1.50
Gatorade	21.5	2.4	19	163	44	.47
Tap Water	1.5					

ders (i.e., Lytren) may be hazardous because a well-meaning mother may give two or three times the desired amount by mistakenly thinking "if a little is good, a lot is better." Avoidance of powders and boiled skim milk would help to avoid hypernatremia.[11]

One should provide the patient with sufficient calories to prevent ketosis and minimize protein catabolism. In general, the minimal amount of carbohydrates necessary is that which provides about 25% of the total caloric expenditure (i.e., 6.5 gm of carbohydrate per 100 calories expended). Caloric content in these beverages is usually derived from carbohydrates. In selecting the proper fluid, the beverage's sugar content must be considered. Most of the clear liquids contain disaccharides (sucrose, etc.) which might increase stool losses by osmotic effect. Pedialyte's sugar is glucose. Even though there is some depression in the active carbohydrate transport system in gastroenteritis, a glucose "drag effect" may occur and thereby increased water absorption. An ideal sugar concentration would be 5% glucose or less.

Coca-Cola is a popular beverage used in the treatment of "bowel upset." The beverage's sugar content and administration of small, frequent amounts of it can be helpful in the management of vomiting. Although other publications have reported it as having a high potassium content, [12,18] in our experience it does not. Our flame photometry studies in Florida and Georgia, a report from Nebraska and personal communication with the chemist of the Coca-Cola Company show the beverage to have a very low potassium value (Table 1). In earlier years, people spoke of "Coke" as "dope" because of the kola nut tree origin of the syrup. Coca-Cola does not contain a narcotic. It does contain caffeine.

In Florida Gatorade is a popular beverage. It is well absorbed. Some infants take it readily, others refuse it. The electrolyte content might be a bit high for babies. I prefer not to give infants oral solutions with a sodium concentration of greater than 15 mEq/L for fear they will take it too freely and develop hypernatremia.

Jell-O water (85 gm package per liter of water) is an inexpensive and palatable mixture.[13] I have found this solution particularly useful in the oral treatment of mild dehydration during infancy. The sodium content of 12 mEq/L is favorable. The potassium concentration, estimated by flame photometry in our laboratory, is relatively low. In Jell-O the caloric content (330 cal/pk) consists principally of carbohydrates (sucrose and dextrose) and of an incomplete protein (gelatin).

In the solution Jell-O water is liquid at room temperature. It becomes semisolid if refrigerated but this condition is readily adjusted by heating or by agitating the mixture. Solidification is likely to take place if more than one package per liter is used. This characteristic provides a safety factor for the overzealous person who does not follow instructions carefully. Mothers should be advised that the stools may assume the color of the ingested Jell-O water. Such advice may serve to avoid apprehension.

In treating vomiting, it is probably worthwhile to let the patient rid himself of the "noxious elements" causing the emesis by allowing some initial vomiting before interrupting the emesis cycle. Older and wise clinicians have known for years that frequent small amounts of concentrated sugared solutions (i.e., coke syrup) result in the abolishment of vomiting in many instances. Why has this been effective? If one can stimulate the stomach and provide an iso-osmolar load, the stomach's tone is increased and conventional peristalsis occurs through a more relaxed pylorus. The use of concentrated sugar solutions apparently increases gastric acid secretion.[7] I prefer to use small (teaspoonful), frequent (q 15 min) sips of flat sugared Coca-Cola in an amount not to exceed one ounce per hour. Once the vomiting has subsided, the fluid volume is increased depending on the needs of the patient. Usually a 24 hour volume of 2500 cc/m^2 or 120 cc/100 cal expended is desirable to handle both maintenance and continuing mild losses of fluid.

The process in diarrhea is quite different in that activation of the gastrocolic reflex results in frequent stooling. "Resting" the bowel in patients with this problem becomes reasonable so that ongoing losses are not magnified. Try to avoid this reflex by giving larger amounts of fluid infrequently (i.e., every 3-4 hours). My preference for beverage is Jell-O water because of its palatability, sodium content, safety and cost. If renal function is good, then during the recovery phase of gastroenteritis I encourage the ingestion of fluids (i.e., orange juice) that are relatively high in potassium content because they are helpful in the reparative process. Orange juice, Lytren and Pedialyte are also high in HCO_3.[18] After 24 hours on clear liquids, the diet can be advanced to include bland solids and diluted milk can be added at 48-72 hours with a return to usual feedings by the third day.

Drugs

Early recognition of gastroenteritis enables the attending physician to control symptoms often without administration of drugs. The occasional use of

mild sedation may be helpful but side-effects and lack of effectiveness make the disadvantages of drug therapy outweigh the advantages.[11,15] There are a myriad of medications used to combat vomiting and diarrhea. Each physician has his favorite. By and large the common thread of effectiveness revolves around a sedation component of these drugs. Sedative antihistamines (Vistaril and Phenergan), barbiturates and phenothiazides (Thorazine and Compazine) tend to relax the patient. However, all of these should be used with caution. Infants should receive no medication because of the potential toxicity of drugs. Prochlorperazine (Compazine) is a very effective antiemetic but its extrapyramidal side-effects are notorious with children and teenagers. It should not be used in these age groups.

Belladonna alkaloids obviate excessive gut motility; however, their anticholenergic effect is almost at a level of toxicity. Opiates cause decreased hydrochloric acid secretion, increased duodenal tone, decreased propulsive contractions and increased anal tone. They are narcotics and must be treated with respect. A combination of diphenoxylate hydrochloride with atropine (Lomotil) diminishes intestinal motility but has been implicated in childhood poisoning. These are not harmless medications and infants should not receive them.

Kaopectate is a mixture of kaolin and pectin that is not particularly helpful. Its real problem comes in its use in small babies where there may be a pooling of fluid in the gut and, therefore, accentuation of dehydration even though the baby's stooling is decreased. This could be a treacherous situation.

Antibiotics may or may not be useful in the treatment of culture-proven bacterial gastroenteritis.[16] There has been much written regarding the pros and cons of their use in diarrhea. Indeed, their use may predispose a patient to a carrier state. One must be cognizant also of their side-effects (increased diarrhea, abnormal flora, individual drug toxicities, etc).

Regardless of the mildness of the gastroenteritis, successful management requires a daily report of progress to the physician. Relevant areas of observation include knowledge of intake, status of circulation and hydration, state of consciousness, depth and rate of respiration, and amount of urination. Serial weight changes are very helpful.

If the child's dehydration approaches 5%, is progressive, or clinical signs of acidosis develop, then hospitalization, serum electrolytes and appropriate parenteral fluid therapy are indicated. However, the majority of youngsters seen early in the course of their illness and cared for properly will not need hospitalization.

Summary

Principles of oral therapy in the treatment of vomiting and of diarrhea differ. Consideration of the underlying pathophysiology is important as well as the proper selection of fluids for oral administration. Stimulation of gastric activity is important in the control of vomiting. The gastrocolic reflex must be forestalled with successful management of diarrhea. Early intelligent management of the patient with gastroenteritis may often avoid the use of drugs, administration of parenteral fluids or the need for hospitalization.

References

1. Guyton, A. C.: Textbook of Medical Physiology, Philadelphia, W. B. Saunders Co., 1956.
2. Hamilton, J. R.: Diarrhea in Infants, Modern Med. 131-140, September 1970.
3. Phillips, S. F.: Fluid and Electrolyte Fluxes in Gut, Hosp. Practice 137-146, March 1973.
4. Watten, R. M.; Morgan, F. M.; Yachal-Na-Songkhla, Y. N.; Vanikiati, B., and Phillips, R. A.: Water and Electrolyte Studies in Cholera, J. Clin. Invest. 38:1879, 1959.
5. Finberg, L.; Cheung, C., and Fleishman, E.: Significance of Concentration of Electrolyte in Stool Water During Infantile Dehydration, Am. J. Dis. Child. 100:809, 1960.
6. Winters, R. M.: Body Fluids in Pediatrics, Boston, Little, Brown and Co., 1st ed., 1973.
7. Davidson, M. and Shirkey, H. C.: Pediatric Therapy, 4th Ed., St. Louis, C. V. Mosby Co., 1971.
8. Bills, C. E.; McDonald, F. G.; Niedermeir, W. and Schwartz, M. C.: Sodium and Potassium in Foods and Water, J. Am. Diet A. 25:304-314, 1949.
9. Rappolt, R. T. Sr. and Uemura, H. S.: Beverage Electrolytes at the Bishop Clarkson Hospital, Omaha, Nebraska, Nebraska M. J. 51:218-219, May 1966.
10. Nomma, F. E. Jr.: Broth Edema in Infants, New England Med. J. 274:107, 1966.
11. Finberg, L.: Hypertonic Hydration. Advances Pediat. 16:325, 1969.
12. Gellis, S. S. and Kagan, B. M.: Current Pediatric Therapy, Philadelphia, W. B. Saunders Co., 1970.
13. Quillian, W. W. II: Jell-O Water—An Adjunct in the Treatment of Infantile Dehydration, Pediatrics 40:#3, 468, September 1967.
14. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, The MacMillan Co., 3rd Ed., 1965.
15. Huff, B. B.: Physicians Desk Reference, Oradell, N. J., Medical Economics Co., 1975.
16. Wallace, C. K.: Enteric Infections, Hospital Med., pgs. 72-86, August 1970.
17. Welt, L. G.: Clinical Disorders of Hydration and Acid-Base Equilibrium, Boston, Little, Brown and Co., 2nd Ed., 1959.
18. Vaughan, V. C. III; McKay, R. J. and Nelson, W. E.: Nelson Textbook of Pediatrics, Philadelphia, W. B. Saunders Co., 10th Ed., 1975.

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SPECIAL ARTICLE

National Health Insurance

Vernon B. Astler, M.D.

Mr. Chairman and honorable committee members, my name is Dr. Vernon B. Astler. I am a fourth generation physician, practicing general and vascular surgery in Delray Beach, Florida. I have received my training at Miami University, Temple University Medical School, and the University of Michigan Graduate School. I have served two years overseas as a Captain in the United States Army Medical Corps in Korea and Japan during the Korean Conflict. I am currently President of the Florida Medical Association and represent over 10,000 physician members of this Association.

I am honored to have been asked to appear before this most important committee. I am here to encourage you to oppose any proposed sweeping National Health Insurance program modeled after the state-supported schemes of Europe and exemplified by the Kennedy-Corman Plan, (S-3, HR 21) which bears striking similarity to the British system.

I shall try to explain why such a sweeping national health system should be opposed based upon logical analysis of fact and figures. Our national health spending in 1973 was $94.1 billion or $441 per person, up 11% over the previous year. If we were to analyze per capita health expenditures by the year, we would see that in 1950 we spent approximately $78 per person or 4.6% of the Gross National Product. By 1960, $141 or 5.2% of the Gross National Product and by 1973, $441 or 7.7% of the Gross National Product.

The economic hardship created by a national health care system simply cannot be borne by our workers and producers. Incidentally, for the first time in our 200-year history, the producers and employed are outnumbered by the nonproducers which include the youth, the disabled, the unemployed, and the retired and elderly. I feel that health care delivery in the United States is related in a general way to other problems facing our country. Problems such as unemployment, high jury awards, the increased cost of living, inflation, the national debt, standards of luxury unimagined 20 years ago, food stamps, the oil crisis, the drug problem, and immorality, just to mention a few. It is my feeling that these problems are influenced in this age of meliorism by permissiveness in our society, the welfare syndrome, and diminished demand for individual responsibility. As we reflect on figures concerning government spending, I think it is not surprising that costs have also risen in a similar way in the field of health care.

Government spending in the United States this year will reach over one-half trillion dollars. A trillion is one thousand billion or a million, million dollars. This amount is twice that spent in 1967 and over 25 times the amount spent in 1940. If we divide this one-half trillion figure by the number of households in the United States, estimated at 71 million in January of 1975, this works out to a total government expenditure per household of almost $7,792 or more than double the figure of $3,592 per household spent in 1965. Now we are hearing again the outcries for a federal program for financing health care for all our citizens: A sweeping program to replace the free enterprise system which has been delivering in this country; a health system which covered 160 million people in this country under private medical insurance plans when Medicare began in 1967 and covered over a 181 million by 1971. Today, Medicare covers only 10% of our total population yet costs the same as insuring the other 90% ($14.7 versus $14.8 billion expended in 1971). I will not argue the comparison since the 65-plus age group carries a higher risk of illness but, certainly it is not nine times greater. Many of you will remember that before Medicare was enacted in 1967, the government actuaries insisted this program would cost a mere $1.6 billion in 1975. But by 1974 the cost was already nine times that much, more than $14 billion.

Let us analyze these costs and let us look at the giant Department of Health, Education, and Welfare. This department is spending almost twice as much each year as the "after tax" profits from all corporations in the United States. If all corporate profits

Dr. Astler is President of the Florida Medical Association, Inc.
*Testimony by Dr. Astler before a subcommittee of the House Ways and Means Committee, Washington, D. C., November 12, 1975.

plus all personal savings of United States citizens were confiscated by the Federal Government, the money would run the Department of HEW for only about 14 months. This swollen, overgrown, giant department now spends more than $118.4 billion a year, more than any other department including the Department of Defense. Incidentally, that is more money than was spent by the entire United States Government in 1960. Now how would a sweeping National Health Insurance program affect these costs?

A brief review of political medicine and national health schemes in Great Britain and Sweden clearly predict the course one could logically expect with a similar national health scheme in the United States. In Great Britain an estimated one-half million people await hospitalization and there is up to a 2½ year wait for elective surgery. Medical doctors have fled the country in great numbers and been replaced in substantial part by physicians migrating from India.

In Sweden, the costs have risen nine fold since the onset of the system in 1960. A Swedish family of four, earning 50,000 kroner a year (about 12,500 U.S. dollars) pays 55% of their income in taxes as compared to 20% for a comparable U.S. family of four in a similar income bracket. There are no hospital beds available in Stockholm and 4,000 people in that city await admission and 1,000 await surgery.

Let us consider the physician shortage. Even the Department of Health, Education and Welfare is retreating somewhat from its former concerns. Former Assistant Secretary of Health, Charles C. Edwards, expressed belief recently that we may be heading for a glut of health professionals. If the United States merely maintains the current output of health professionals in our present institutions, by 1985 we will have 50% more physicians, 40% more dentists, and 60% more registered nurses than we had in 1970. This does not take into consideration the marked influx of foreign medical graduates. Yes, we hear of the doctor shortage and yet the M.D. physician population has grown 33.6% since 1964, while the overall U.S. population is up 9.1%.

I would say it would be foolhardy to embark on a major overhaul of the health care system considering the fact that over 181 million Americans have at least one private health insurance policy and 74 million Americans have comprehensive major medical policies. If we add the 24 million actual recipients of Medicaid, we see that over 90% of the American people are presently covered by some health care coverage. In a recent nationwide poll, Americans were asked to rate 16 listed concerns in their order of importance. It was of interest that inflation and government spending were 1 and 2, whereas health care was listed 15th.

Where are the areas of need? First, catastrophic insurance is essential, for none of us can afford a catastrophic illness such as a stroke, crushed pelvis, or a massive and disabling heart attack. Actuaries have estimated that if catastrophic insurance coverage were offered to and accepted **by every** American, the cost would be a mere $50 per family per year and less than $25 per year per individual. I might add that the thought of consumer abuse for catastrophic health insurance does not concern me since most folks are not going to go out and have a catastrophic illness merely to collect on their insurance. However, abuse certainly would result if our government were to offer first dollar health care coverage for all citizens. Under such a system the "worried well" would clog the health care facilities in our country. I am alluding to those who are not truly ill but, simply suspect they are, or are usurping the benefits of the system because it is offered at government expense.

Second, care to the unemployed, the physically handicapped and the self employed should be a matter for national concern. I do not feel the health insurance industry or the health providers could or should assume the cost for these truly noteworthy categories.

Third, federal assistance for health is needed for the 10 to 15% of our population for whom the barrier is **truly** cost. It is possible to provide mainstream health care to most disadvantaged people by introducing them into the mainstream. It is not necessary to move or totally disrupt the mainstream. The two key words dominating the successful operation of our system are **access** and **mainstream.** Many people lack access to the mainstream health care, either from lack of education or lack of personal initiative to seek it. Here greater emphasis on health care education is needed; others need access because of matters of geography or cost.

Fourth, the problem of rural health care is substantial but should be dealt with separately. The numbers of people here are small and the geography is vast. Fewer than 3% of our population reside more than 20 miles from some medical facility. It is likely that a transportation system has more to offer these people than redistribution of medical personnel or construction of new and costly health facilities.

Lastly, I would like to say a word about nursing homes for I feel some changes are necessary. Most of our nursing home facilities offer one standard class of care. This concept decidedly needs updating. Just as we grade patient care in hospitals, the same graded care should be available for nursing home patients. Those with serious strokes, terminal cancer, pulmonary or kidney disease should be separated from others and should pay a price commensurate with the type of care rendered. Others who are merely unwanted by the family or without relatives, who are able as ambulatory patients to dress, bathe, and eat by themselves should be offered domiciliary care. This type of care we offered in years past in so called "rest homes". Of course, the cost of care for these individuals must be in a much more realistic price range and they must be separated from those who are seriously ill.

In summary, I would say that Americans have access to the finest medical care in the world. Our system of essentially private free enterprise health delivery has its failings to be sure, but it is infinitely superior to the state-supported schemes of Europe. Let us make changes in a thoughtful and sensible way but not embark on a major overhaul of a health care system which is delivering. I would like to close by reading ten rules of conduct for individuals and nations.

1. You cannot bring about prosperity by discouraging thrift
2. You cannot strengthen the weak by weakening the strong
3. You cannot help small men by tearing down big men
4. You cannot help the wage earner by pulling down the wage payer
5. You cannot further the brotherhood of man by encouraging class hatred
6. You cannot help the poor by destroying the rich
7. You cannot establish sound security on borrowed money
8. You cannot keep out of trouble by spending more than you earn
9. You cannot build character and courage by taking away man's initiative and independence
10. You cannot help permanently by doing for them what they could and should do for themselves.

These words were spoken by Abraham Lincoln.
Thank you for your attention and the privilege of sharing these thoughts.

▶Dr. Astler, 2800 Seacrest Blvd., Boynton Beach, Florida 33435.

MEDICINE'S LEADERSHIP SCORED HIGHEST in public esteem among 16 professions and institutions rated in a recent Harris Survey. Those questioned in the survey were asked whether the leaders in each group "really know what most people want" or are "mostly out of touch with their constituents."

69% EXPRESSED CONFIDENCE IN MEDICINE'S LEADERSHIP, while Congress placed last among the 16 groups with 34%. Television news placed second with 66%, banks third with 64%, and the press fourth with 59%. Organized labor was eighth with 45% and major companies tenth with 39%. The Supreme Court was thirteenth with 38% and the White House was fourteenth with 35%.

IN ANOTHER POLL, ALTHOUGH 8 OUT OF 10 PEOPLE were either "very" or "fairly" satisfied with the quality and availabiilty of their health care, the cost of care was cited as "unreasonable" by a majority of those questioned. The findings of this poll were presented by the Roper Organization, Inc., at a meeting of the National Assn. of Blue Shield Plans. The Roper survey also showed that 50% of a random sample of Americans favors private health insurance and that 41% favors national health insurance. In answer to another question, more than 60% of those polled said too little was spent on health by the federal government.



HILL CREST HOSPITAL — For Intensive Treatment of Psychiatric Disorders

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

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HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

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EDITORIALS

Caduceus

THIS MONTH'S COVER PAINTING

Art and medicine have been closely related since the beginnings of history. Paintings by great artists, such as Rembrandt's immortal "The Anatomy Lesson" and "Christ Healing the Leper," often dealt with medical subjects, while a more recent work, "The Doctor" by Luke Fields, has been the inspiration for many doctors-to-be. Art and medicine are both rife with symbolism, too, as evidenced by the winged staff of Mercury, herald of the gods, with snake entwined in the classic symbol of the CADUCEUS. Even more significant is the symbolic emblem of Aesculapius, god of medicine—traditionally pictured as holding a winged staff with single snake—the universally recognized symbol of our calling.

All of these symbols are represented, or implied, in "CADUCEUS," this month's Journal cover painting by Lee Adams. A self-taught artist, Lee Adams had gained worldwide fame as a painter of the Florida landscape and wildlife before his untimely death in an automobile accident on November 16, 1971. Painted in 1956 for the new headquarters building of the Florida Medical Association in Jacksonville, CADUCEUS is one of the loveliest of his paintings and the original remains on display in the FMA building.

Lee Adams began painting at the age of six in the family home at Mandarin, a small village on the St. Johns River just south of Jacksonville. After graduating from Rollins College, he spent almost ten years as a protege of Dr. George H. Opdyke and Dr. David Fairchild, much of it at the famous Fairchild Gardens near Miami. His intuitive gift for portraying the Florida milieu quickly gained him a wide reputation in the art world and he was a veteran of sixty-nine one man shows in the United States and abroad. His paintings are represented in the permanent collections of great museums throughout the world.

With the instinctive and unconscious inspiration of the true artist, Lee Adams created in CADUCEUS many of the symbolic aspects of the medical profession. Of the painting, he wrote: "The Florida Blue Jay, CYANOCITTA CRISTATA, so often taken for granted as a common bird of the garden or woodland, is actually one of the most beautiful birds of North America. Upon close examination, the texture and color of the feathers present a marvelous blend of lavender, blue and blue-green. . . . Extrovert of the bird world, the Blue Jay is often thought to be a noisy cut-up. But no bird is capable of greater stealth at nesting time than the cautious parent Jay. Their loud alarm "Jay! Jay!" cries are known to everyone who has watched their riot squad assail an intruder cat or hawk. A noisy band will quickly gather to make life miserable for a sleeping owl by day, or to pursue a snake."

Of the tree branch that forms an integral part of CADUCEUS, Lee Adams also wrote: "Coral honeysuckle, frequently called Woodbine in the South, is one of our most attractive wild American plants. Adding color with charm, delicacy and restraint, very old specimen plants of LONICERA SEMPERVIRENS are twined against the colonnade flanking the main entrance to Mt. Vernon, home of George Washington. . . . A high climbing woody vine, it bears clusters of coral-colored, trumpet-shaped flowers with orange or yellow throats."

In CADUCEUS the artist has caught the beauty and drama of the scene with his usual remarkable facility for treating natural subjects. The threat of the Black Racer gliding to attack the hidden nest; the "lavender, blue and blue-green" in the out-thrust wings of the angry bird; the flowers of the Woodbine with their "orange or yellow throats;" the sturdy vine itself and its almost transparent green leaves —all this, the artist has caught in a burst of striking beauty and drama that cannot but please the eye of the beholder.

In this lovely painting, however, Lee Adams portrayed much more than simply the beauty of the woodland scene and its inhabitants. He also caught much of the symbolism inherent in the history and

traditions of medicine. The serpent twined about the rugged staff represents the insignia of the herald—a role the living Blue Jay plays over and over for the bird community—that is part of the traditional CADUCEUS of medicine. Woodbine certainly symbolizes the dependence of medicine upon plants as sources for healing drugs. And in Greek mythology, the staff, serpent and wings have always been part of a triad distinguishing those who have followed Aesculapius, god of healing in the Hellenic Pantheon. What more appropriate name could be given then to a painting of such rare beauty and peculiarly medical significance than CADUCEUS?

Frank G. Slaughter, M.D.
Jacksonville



A LIMITED EDITION PRINTING OF THE PAINTING "CADUCEUS", BY LEE ADAMS, IS NOW AVAILABLE (22½" x 28½" unframed) IN RETURN FOR A $300 TAX DEDUCTIBLE DONATION TO THE FLORIDA MEDICAL FOUNDATION. (Sales tax is not applicable.)

Each print will be mailed "Special Handling—Insured" in a hard back container.

The Florida Medical Foundation has completed arrangements with the Lee Adams Family Trust to make available this special limited edition of 500 prints of the "Caduceus" by Lee Adams. Each print will be NUMBERED AND CERTIFIED by the Trust. The proceeds will be utilized by the Foundation for its primary purposes:

1. Improvement of the health and of the medical care of people of Florida.
2. Sponsorship of graduate and postgraduate medical education.
3. Aid to persons needing financial assistance who are pursuing an education in medicine.
4. Aid to deserving indigent or destitute physicians in need of assistance.
5. Promotion and sponsorship of medical research.

IF YOU WISH TO RECEIVE A PRINT OF THE CADUCEUS, PLEASE FORWARD YOUR TAX DEDUCTIBLE DONATION IN THE AMOUNT OF $300.00 TO THE FLORIDA MEDICAL FOUNDATION, P. O. BOX 2411, JACKSONVILLE, FLORIDA 32203.

The Fifth Pathway

The so-called "Fifth Pathway" became law when the legislature in its 1975 session passed House Bill No. 435, an amendment to the Medical Practice Act now Chapter 75-154, Florida Statutes. Four pathways already existed by which foreign medical school graduates or students could enter American medical education programs or become eligible for licensure in the United States.

As defined by the American Medical Association, the Fifth Pathway is open only to the student in a foreign medical school approved by the World Health Organization. He must have completed all requirements of the school except internship and/or social service and previously his premedical training in an accredited American college or university and been qualified for admission to an accredited United States medical school. The student is eligible to enter an academic year of supervised clinical training in a hospital affiliated with a U. S. medical school approved by the Council on Medical Education of the American Medical Association. The school approves his academic record and the score attained on a screening examination such as Part I of the National Board of Medical Examiners, Federation Licensing Examination (FLEX) or Educational Council for Foreign Medical Graduates (ECFMG) examination. Upon completion of clinical training he is eligible to begin the first year of an AMA approved graduate training program.

The Fifth Pathway is one of many recent developments which makes it difficult to separate fact from fiction and logic from emotion. The entire concept appears to be based upon an effort to bypass established channels.

Its proponents point out that the AMA has repeatedly approved the concept. They emphasize that the students involved are highly motivated and qualified graduates of U. S. colleges and universities who were unable to pursue their medical education because of overcrowding in our own medical schools; thus we have a moral obligation. The year of clinical training would correct whatever deficits might have been inherent in their education and the sponsoring American medical school would have the opportunity to make certain their work is satisfactory before entry into a program of graduate medical education. Proponents point out that this program offers the means to obtain additional physician manpower at much less cost to the public than the cost of educating a student in medical schools within the United States. The students would avoid a year or two of social service in a foreign country, which is said to be of little or no educational value.

Those opposing the Fifth Pathway, including the Florida Medical Association's Board of Governors and House of Delegates, and the Board of Medical Examiners, believe it represents a dilution of the quality of clinical medical education programs and lowers the standards for medical licensure in Florida.

At present there are no standards for a year of supervised clinical training and no national academic controls. A license obtained under this program would give the physician a nonnegotiable certificate, since many states do not recognize the Fifth Pathway. The facilities for medical education in Florida already are overstressed and the additional burden would decrease the availability of educational resources for those already enrolled. Authorization of the Fifth Pathway would encourage more United States citizens to seek medical education abroad and possibly result in a proliferation of such foreign medical schools.

The Fifth Pathway is particularly applicable to the autonomous medical school in Guadalajara, Mexico. Students enter it with the knowledge that completion of their medical education includes the year or two of social service in that country. A modality that circumvents this service brings up the moral question of whether or not the individual has fulfilled an established contract.

Chapter 75-154 states that the foreign medical school graduate applying for licensure need not present an ECFMG certificate or pass the American medical examination for foreign graduates if he has fulfilled the requirements previously mentioned for entering the Fifth Pathway. He must have passed Parts I and II of the National Board of Medical Examiners examination or the ECFMG equivalent and completed the academic year of supervised clinical training. The graduate must have been a resident of Florida for one year.

At the present time no one knows:

1. How many foreign medical school students qualify under this law or how many will apply for licensure.

2. How many openings for a year of supervised clinical training can be made available by our medical schools or community educational programs affiliated with a medical school.

3. What a year of supervised clinical training actually constitutes or implies and what component must be utilized to refurbish or enhance the student's deficiencies in the basic sciences.

4. The educational deficiencies of these foreign medical school graduates and how the deficiencies can be measured.

5. Whether such deficiencies can be corrected by one year of additional training.

6. If a precedent has been set which might result in a similar change in our laws to allow other persons in the health field who have no M.D. degree to become licensed to practice medicine.

7. Whether compliance is mandatory or voluntary.

8. What pressure will be applied to our medical schools to force implementation of the programs.

9. Whether only better students will be selected for this program when, in fact, those less academically qualified may actually be in greater need of additional education, and

10. Who pays for the extra cost of this type program requiring individual analysis, counseling and training.

The answers to these questions should have been considered prior to passage of the legislation; not to have done so borders on irresponsibility. The fact is—we have a new law and it will be enforced.

Dr. George S. Palmer's statement should guide our philosophy of compliance. He is executive director of the Florida Board of Medical Examiners. "Our first and foremost duty is the protection of the public in assuring that only competent and qualified M.D.'s are granted the privilege of licensure to practice medicine in our state."

George H. McSwain, M.D.
Daytona Beach

Dr. McSwain is Immediate Past Chairman of the Florida Medical Association's Committee on Medical Education.

Further Comments on The Fifth Pathway and Dr. McSwain's Guest Editorial

During the past state legislative session, two separate bills dealing with the "Fifth Pathway" were introduced into the Senate and House of Representatives.

Questions related to the Medical Practice Act are not generally considered in the purview of medical schools; however, since students entering in the "Fifth Pathway must receive a year of supervised clinical training, under the direction of a United States medical school, approved by the Liaison Committee of Medical Education," the state's three medical schools felt compelled to voice their concerns and objections before the legislative subcommittees dealing with this complex issue.

During the past five years, the three medical schools in the State of Florida have increased undergraduate and postgraduate enrollment substantially. Medical school faculty traditionally believe it is essential to have a low student to faculty ratio in order to provide high quality medical education. It would be extremely unfair to students who pay high tuition and have met the challenge of being accepted to an American medical school to have their training diluted by expanding the size of the clinical training program to include graduates of foreign medical schools. These students have not passed the qualifying examinations which are required of our own students to proceed with their clinical clerkships and elective programs. It is also unfair to the student who has gradauted from a foreign medical school to be in the position of an observer and not an active participant. Since these "Fifth Pathway" students are not enrolled in medical school and are not licensed, their professional activities must be restricted considerably. In no way can this be justified as quality education. A greater concern is the fact that these students would require even more supervision than our regular students since they generally come from medical schools that have been unable to provide clinical experiences comparable to that available in the United States.

Fortunately, both the Chairman of the Senate and House of Representatives Health and Rehabilitative Service Committee permitted their respective bills

to be amended to include the requirement that students pass Part I and Part II of the National Board of Medical Examiners or the ECFMG equivalent.

It appears that the thrust of these important changes have not been completely understood by the physicians of Florida, the licensing board and many of our colleagues in medical education. The percentage of students trained in foreign medical schools that pass these examinations is low; if they were passing the examination they would be transferring back into American medical schools and obtaining their medical education in this country. Students taking the first part of the National Boards two years after they have taken courses in biochemistry, anatomy, etc., will probably have greater difficulty in successfully completing these very demanding tests. If a student does pass Part I and Part II of the National Board of Medical Examiners, it means that their training has probably been comparable to that of the students trained in this country and that they are capable of performing at a competent clinical level provided they have an adequate internship in a medical school affiliated hospital.

I feel that the amendments that were offered on the floor of the House of Representatives and the legislation which was signed on June 22nd by Governor Askew in fact was the possible compromise for the licensure board, the medical schools and the physicians of this state. It means that any individual applying for licensure in this state must successfully complete national standardized accredited tests before they are eligible for licensure. To make the law more restrictive than that probably would be unconstitutional since it might be prejudicial to those individuals who receive education outside of this country. To leave legislation as it is is fair to the students who are capable of passing the test and fair to all of us who practice and are interested in the highest quality of care in the State of Florida.

Finally, I should note, the Executive Committee of the Faculty of the University of Miami School of Medicine voted unanimously against the concept of the "Fifth Pathway." I have been informed that the Deans of the other two Florida medical schools and their respective Executive Committees also were unanimously against the concept. It is my understanding that the passage of House Bill 435 in its amended version has minimized some of the concerns of the medical school faculty members.

Although House Bill 435, as passed by the Florida Legislature, is by no means a panacea and the cogent questions raised by Dr. McSwain in his guest editorial require answers, I hope that the legislature will not attempt to eliminate the National Board or ECFMG requirements. To do so will substantially reduce the state's ability to train students, minimize the qualifications for practice in this state and ultimately affect the standards of health care rendered by our physicians.

Bernard J. Fogel, M.D.
Assistant Vice President for Medical Affairs
University of Miami School of Medicine

LASTING SATISFACTION

There is no truer and more abiding happiness than the knowledge that one is free to go on doing, day after day, the best work one can do, in the kind one likes best, and that this work is absorbed by a steady market and thus supports one's own life. Perfect freedom is reserved for the man who lives by his own work and in that work does what he wants to do.

—R. G. Collingswood



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct nontherapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

Medical News Around the State

The Institute for Health Administration and Research . . . of the University of Miami has announced an awards program for research in the administration of health care.

Purpose of the awards is to stimulate research in the administration of health care. Proposals, not completed research, will be eligible for these awards. They may deal with any part of health care as long as it relates in a useful and practical way to specific and worthwhile administration and management problems.

Awards include $2,500 for first place; $1,000 for second; $500 for third; and five merit awards of $250 each.

Additional information may be obtained from Dr. Thomas A. Natiello, University of Miami, P.O. Box 248524, Coral Gables, Fla. 33124.

Charlotte H. Kerr, M.D. of Seminole . . . has been elected Vice President of the American Medical Women's Association.

Dr. Kerr is an obstetrician and gynecologist, and her husband, John Kerr, M.D., is a urologist. The new AMWA officer is a member of the Pinellas County Medical Society and the Florida Medical Association.

W. Dean Steward, M.D., of Jacksonville . . . has accepted appointment as fulltime Director of the Jackson County Health Department.

A Past President of the Florida Medical Association, Dr. Steward closed out his internal medicine practice in Orlando last summer and joined the Florida Division of Health in Jacksonville.

He was recommended for the Jackson County post in Marianna by another former FMA President, James T. Cook, M.D., of Marianna.

A. Ashley Weech, M.D., of Gainesville . . was honored by friends and colleagues recently on the occasion of his 80th birthday. Dr. Weech is a former Editor of the **American Journal of Diseases of Children.**

Gilles R. G. Monif, M.D., Associate Professor of Obstetrics and Gynecology . . . at the University of Florida College of Medicine, has received the American Medical Writers' award for the best multi-author medical book of 1975.

Dr. Monif compiled, edited and wrote portions of the book, **Infectious Diseases in Obstetrics and Gynecology,** a compilation of current diagnostic and therapeutic information on infectious diseases of the female genital tract and the fetus. Among the co-authors are Drs. David S. Bard and James Daly, both also of Florida's Department of Obstetrics and Gynecology.

Andrew F. Giesen, Jr., M.D., . . . of Ft. Walton Beach, has been elected First Vice President of the 22,000-member Southern Medical Association. Dr. Giesen's election to office came at SMA's 69th Scientific Session at Miami Beach in November.



Robert Grayson, M.D., of Miami Beach (right), Chairman of the Florida Chapter of the American Academy of Pediatrics, accepts Wyeth Laboratories' "Outstanding State Chapter Award" from Justin M. McCarthy, a Wyeth official. The presentation was made at the American Academy's Annual Meeting in Washington. The Florida Chapter was cited for its efforts in promoting child health care and in "effectively furthering the objectives of the Academy."

DYAZIDE®

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



Awake too long

Awake too often during the night

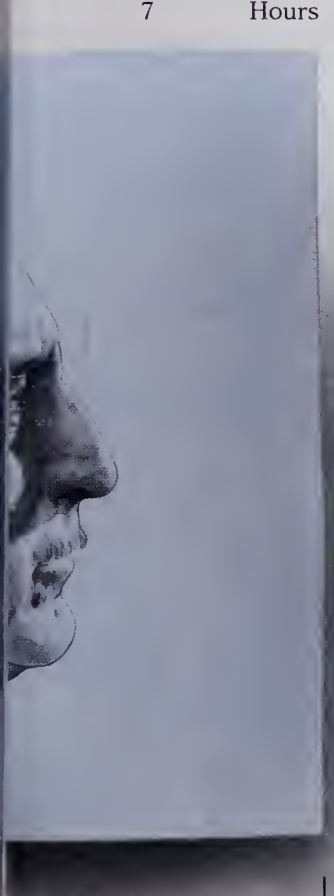
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories[1-4]

The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

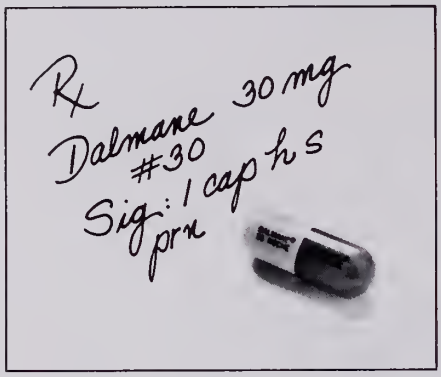
- induces sleep rapidly
- reduces nighttime awakenings
- lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ℞ IV



Objectively proved in the sleep research laboratory, Dalmane

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



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ROCHE LABORATORIES
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Nutley, New Jersey 07110

ORGANIZATION

102nd FMA Annual Meeting Preliminary Program

A special Symposium on Hypertension will be the lead-off event for the 102nd Annual Meeting of the Florida Medical Association at Hollywood, Fla., in May.

Attendance near or exceeding record levels is anticipated for the sessions beginning on Wednesday, May 5, and ending on Sunday, May 9, at the Diplomat Hotel.

The two-hour hypertension program will begin at 1:00 p.m. on Wednesday and will feature papers on epidemiology, pathophysiology, surgical aspects, and radiological evaluation of one of the nation's most prevalent diseases, according to Charles P. Hayes, M.D., of Jacksonville, who arranged the symposium.

Last year, a Wednesday afternoon scientific session (Section on Internal Medicine) was introduced to afford FMA members maximum opportunity to earn credit under the Association's continuing education program. An estimated 375 physicians attended that section, and it was decided to have a Wednesday afternoon program again this year.

The Symposium on Hypertension will be followed by the traditional Section on Internal Medicine.

O. Frank Agee, M.D., of Gainesville, General Program Chairman, said there would be about 30 scientific sections spread over Wednesday afternoon, Thursday afternoon and evening, and Friday and Saturday morning and afternoon. The entire program was near completion as this issue of **The Journal** went to press.

Another new feature of the 1976 program will be a "Dialogue" series underwritten by Pfizer Laboratories. There will be four one-hour segments, two on Thursday afternoon and two on Friday morning. In each program, a guest speaker will give a five- or ten-minute overview of his subject and respond to specific questions from the audience for the remainder of the period. Subjects and guest speakers will be published in a later issue of **The Journal** and "Briefs."

Meanwhile, Exhibit Chairman E. Eddy Burns, M.D., of St. Petersburg, reported a large number of applications for exhibit space and said this year's scientific and educational exhibit promises to be a useful educational tool for the practicing physician.

As in 1975, the scientific program is structured in a way that FMA members may earn up to 20 hours of mandatory credit, a full year's quota, under the FMA's program.

Here is a schedule of scientific sections with information current to mid-January (physicians should consult the Official Convention Program for possible time and other changes:

WEDNESDAY AFTERNOON—MAY 5

SYMPOSIUM ON HYPERTENSION

(Sponsored by FMA Committee on Continuing Medical Education)

Wednesday—1:00 p.m. to 3:00 p.m.

Charles P. Hayes, M.D., Jacksonville
Program Chairman

"Epidemiology of Hypertension" (Speaker to be Announced)

"Pathophysiology of Hypertension," J. Caulie Gunnels, M.D., Professor of Medicine, Duke University School of Medicine, Durham, N.C.

"Surgical Aspects of Hypertension," John Foster, M.D., Department of Surgery, Vanderbilt University School of Medicine, Nashville, Tenn.

"Radiological Evaluation of Hypertension," Juri Kaude, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville.

"Diagnostic Workshop and Treatment of Hypertension" (Panel)—Drs. Gunnels, Foster and Kaude.

Questions and Answers

Adjournment

SECTION ON INTERNAL MEDICINE

(Co-sponsored by Florida Society of Internal Medicine and American College of Physicians)

Wednesday—3:15 p.m. to 4:15 p.m.

Charles P. Hayes, M.D., Jacksonville
Program Chairman

"Shock Lung," Roy Behnke, M.D., Chief of Medicine, University of South Florida College of Medicine, Tampa.

Questions and Answers

"The Hepatitis Dilemma," Eugene Schiff, M.D., University of Miami School of Medicine, Miami.

Questions and Answers

Adjournment

THURSDAY AFTERNOON—MAY 6

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians and Florida Thoracic Society)

Thursday—2:00 p.m. to 5:00 p.m.

Roberto Llamas, M.D., Miami Beach
Program Chairman

"Recent Advances in the Management of the Patient with Chronic Airways Obstruction," Ben Branscomb, M.D., Professor of Medicine in Emphysema and Respiratory Disease, and Clinical Director of Spain Rehabilitation Center, University of Alabama School of Medicine, Birmingham, Ala.

"Chronic Obstructive Airways Diseases—The Constant Challenge" (Panel).

Moderator: James R. Jude, M.D., Chief of Surgery, St. Francis Hospital, Miami Beach, and Clinical Professor of Surgery, University of Miami School of Medicine.

Panelists:

Ben Branscomb, M.D., Birmingham, Ala.

"Early and Simple Treatment of the Chronic Obstructive Lung Disease Patient," James W. Wynne, M.D., Assistant Professor of Medicine and Anesthesiology, University of Florida College of Medicine, Gainesville.

"Maintenance and Support of Patients with Advanced Chronic Obstructive Lung Disease," Asher Marks, M.D., Clinical Associate Professor of Medicine, University of Miami School of Medicine.

"Causes of Acute Respiratory Failure in the Chronic Lung Disease Patient," Gerald N. Olsen, M.D., Medical Director, Pulmonary Medicine, St. Vincent's Medical Center, Jacksonville.

"The Chronic Obstructive Lung Disease Patient in the ICU," E. F. Klein Jr., M.D., Associate Professor of Anesthesiology and Surgery, University of Florida College of Medicine, and Director of the Surgical Intensive Care Unit, Shands Teaching Hospital, Gainesville.

Cardiology Hour

Adjournment

SECTION ON ADVANCED LIFE SUPPORT

(Co-sponsored by Florida Chapter of the American College of Emergency Physicians and the Florida Society of Anesthesiologists)

Thursday—1:30 p.m. to 5:00 p.m.

J. Clifford Findeiss, M.D., Miami

John C. Kruse, M.D., Jacksonville
Program Co-Chairmen

This jointly sponsored session by the Florida Chapter of the American College of Emergency Physicians and the Florida Society of Anesthesiologists is designed to train physicians in the skills of Advanced Life Support as defined by the American Heart Association.

The sessions include some didactic instruction, but place strongest emphasis on the technical psycho-motor skills of Advanced Life Support. The maximum number of registrants for this special session has been limited to 50.

Pre-registration for this session is required, and packets of course information will be distributed at the time of pre-registration. A separate desk close to the main FMA registration desk will be open for this pre-registration.

Separate performance stations will be established in the course where technicians will be demonstrating, and each registrant will have an opportunity to practice that technique. These stations are:

1. Basic Life Support
2. Adjuncts for Airway and Mechanical Jointing
3. Endotracheal and Esophageal Intubation
4. Placement of Intravenous Fluid Life Lines
5. Recognition of a Ventricular Fibrillation and Defibrillation
6. Recognition of Dysrhythmias via Oscilloscope—Dynamic
7. Recognition of Dysrhythmias from Paper Recordings—Static
8. Drug Therapy for Dysrhythmias

Adjournment

SECTION ON PSYCHIATRY

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

Thursday—1:30 p.m. to 4:30 p.m.

John E. Adams, M.D., Gainesville
Program Chairman

"Practical Psychiatry for Non-Psychiatrists"

Moderator: John E. Adams, M.D., Professor and Chairman, Department of Psychiatry, University of Florida College of Medicine, Gainesville.

"Diagnosis and Management of the Hyperkinetic Child," Gilbert Milner, M.D., Chief, Child Psychiatry Inpatient Services; and Eric A. Baum, M.D., Chief, Division of Child and Adolescent Psychiatry, University of Florida College of Medicine, Gainesville.

"Differential Diagnosis of Adolescent Turmoil," Martin Lazoritz, M.D., Chief, Adolescent Inpatient Psychiatry Unit; and Eric A. Baum, M.D., Chief, Division of Child and Adolescent Psychiatry, University of Florida College of Medicine, Gainesville.

"Anxiety and Depression in Primary Care," John M. Kuldau, M.D., Associate Professor of Psychiatry, and Chief, Program in Social and Community Psychiatry, University of Florida College of Medicine, Gainesville.

"Patterns of Adjustment to Chronic Illness," Geoffrey J. Newstadt, M.D., Assistant Professor of Psychiatry, and Chief, Consultation-Liaison Service, University of Florida College of Medicine, Gainesville.

Adjournment

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology)

Thursday, 1:30 p.m. to 4:30 p.m.

Roy D. Altman, M.D., Miami
Program Chairman

"Rheumatoid Arthritis," Jacques Caldwell, M.D., Chief of Immunology, Rheumatology and Allergy, University of Florida College of Medicine, Gainesville; and Norman Gottlieb, M.D., Associate Professor of Medicine, University of Miami School of Medicine, Miami.

"Collagen Vascular Disease," J. Claude Bennett, M.D., Professor of Medicine, and Director, Division of Clinical Immunology and Rheumatology, Medical College of Alabama, Birmingham, Ala. and Richard S. Panush, M.D., University of Florida College of Medicine, Gainesville.

"Non-articular Rheumatism," Louis Sales, M.D., Jacksonville.

"Newer Anti-Inflammatory Arthritis Medicines," Wilbur Blechman, M.D., Clinical Assistant Professor of Medicine, University of Miami School of Medicine, Miami.

Adjournment

DIALOGUE

(Presented through the courtesy of Pfizer Laboratories)

Thursday—2:00 p.m. to 4:00 p.m.

Each one-hour segment of Dialogue will begin with a five- or ten-minute overview of a topic of current interest by a guest speaker. The remainder of each hour will include audience questions.

Section I (Speaker and Subject to be Announced)

Section II (Speaker and Subject to be Announced)

"Management of the Dizzy Patient" (Roundtable I)

Moderator: Herbert Fields, M.D., North Miami Beach

Speakers: Richard Gacek, M.D., Boston, Mass.; Anthony Maniglia, M.D., Miami; and Herbert Silverstein, M.D., Sarasota.

Break

"Correction of the Deviated Nose: Function and Aesthetics" (Round table II)

Moderator: Robert L. Simons, M.D., North Miami Beach

Speakers: Sidney Feuerstein, M.D., New York, N.Y.; Richard Farrior, M.D., Tampa; and Dr. Simons.

Adjournment

SYMPOSIUM ON GOVERNMENT HEALTH PLANNING AND ORGANIZATION

(Sponsored by FMA Council on Medical Systems)

Friday—8:30 a.m. to 10:45 a.m.

James L. Borland Jr., M.D., Jacksonville
Program Chairman

"Public Law 93-641 (National Health Planning Act): Summary and Commentary" (Speaker to be Announced).

Questions and Answers

"Reorganization of the Florida Department of Health and Rehabilitative Services" (Speaker to be Announced).

Questions and Answers

"Health Service Areas (HSAs) in Florida" (Speaker to be Announced).

Questions and Answers

Adjournment

THURSDAY NIGHT—MAY 6

GENERAL SESSION

(Sponsored by FMA Committee on Continuing Medical Education)

"Dr. Jekyll and Dr. Hyde—the Celluloid Doctors," Ralph Crawshaw, M.D., Writer and Lecturer, Portland, Ore.

FRIDAY MORNING—MAY 7

SECTION ON OTOLARYNGOLOGY

(Co-sponsored by Florida Society of Otolaryngology)

Friday—8:00 a.m. to 10:45 a.m.

Herbert Fields, M.D., No. Miami Beach

Robert L. Simons, M.D., No. Miami Beach
Program Co-Chairmen

SECTION ON UROLOGY, OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Urological Society and Florida Obstetric and Gynecologic Society)

Friday—8:30 a.m. to 10:30 a.m.

Woody N. York, M.D., Tampa
Program Chairman

"Management of Primary and Recurrent Stress Urinary Incontinence," Robert L. Vermillion, M.D., Assistant Professor of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa.

"The Urological Evaluation and Management of Urinary Incontinence in Females," Roy P. Finney, M.D., Professor and Chief of Urology, University of South Florida College of Medicine, Tampa.

"Management of Postoperative Bladder Drainage," James M. Ingram, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa.

"The Urinary Tract During Pregnancy," Woody N. York, M.D., Associate Professor of Urology, University of South Florida College of Medicine, Tampa.

Break

Panel Discussion

Panelists:

Robert L. Vermillion, M.D., Tampa

Roy P. Finney, M.D., Tampa

James M. Ingram, M.D., Tampa

Woody N. York, M.D., Tampa

Adjournment

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter, American College of Emergency Physicians)

Friday—8:15 a.m. to 10:45 a.m.

Jere D. Creed, M.D., Coral Gables
Program Chairman

"Introduction and Overview of Advanced Life Support," Jere D. Creed, M.D., Coral Gables.

"Cardiac Monitoring and Dysrhythmia Recognition," Neil J. Principe, M.D., Miami.

"Essential and Useful Drugs in Emergency Cardiac Care," Alfred Fevrier, M.D., Miami.

"Acid-Base Balance in Emergency Cardiac Care," Edward Spievack, M.D., Hollywood.

"Life Support Adjuncts for Airway and Ventilation," John Caliendo, M.D., Miami Lakes.

DIALOGUE

(Presented through the courtesy of Pfizer Laboratories)

Friday—8:45 a.m. to 10:45 a.m.

Each one-hour segment of Dialogue will begin with a five- or ten-minute overview of a topic of current interest by a guest speaker. The remainder of each hour will include audience questions.

Section III (Speaker and Subject to be Announced)

Section IV (Speaker and Subject to be Announced)

FRIDAY AFTERNOON—MAY 7

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)

Friday—1:30 p.m. to 4:45 p.m.

Richard C. Reynolds, M.D., Gainesville
Program Chairman

Moderator: Richard C. Reynolds, M.D., Professor and Chairman, Department of Community Health and Family Medicine, University of Florida College of Medicine, Gainesville.

"Ethics in Everyday Medical Practice," Dr. Ronald Carson, Chief, Division of Social Sciences and Humanities, Department of Community Health and Family Medicine, University of Florida College of Medicine, Gainesville.

"Medical Education and Rural Health Care," Wilmer J. Coggins, M.D., Chief, Division of Rural Health, Department of Community Health and Family Medicine, University of Florida College of Medicine, Gainesville.

"The Content of Ambulatory Health Care"

Richard A. Henry, M.D., Chief, Division of Graduate Medical Education, and Director, Family Practice Residency, Department of Community Health and Family Medicine, University of Florida College of Medicine, Gainesville.

James C. Baggett, M.D., Associate Director, Family Practice Residency, Department of Community Health and Family Medicine, University of Florida College of Medicine, Gainesville.

Dr. Mario Ariet, Chief, Division of Computer Sciences, Department of Community Health and Family Medicine, University of Florida College of Medicine, Gainesville.

Break

"Common Clinical Problems in Out-Patient Cardiology," J. Russell Green, M.D., Clinical Director, Family Practice Program, Department of Community Health and Family Medicine, University of Florida College of Medicine, Gainesville.

"Psychosocial Problems Confronting the Family Physician," John Adams, M.D., Professor and Chairman, Department of Psychiatry, University of Florida College of Medicine, Gainesville.

"Doctors in Literature," Dr. H. Gene Moss, Associate Professor of English, University of Florida, Gainesville.

Adjournment

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)

Friday—2:00 p.m. to 4:15 p.m.

Manuel L. Carbonell, M.D., Miami
Program Chairman

"An Update in Colon and Rectal Surgery Anesthesia," Roger Walker, M.D., Chief, Department of Anesthesia, Mercy Hospital, Miami.

"Herpes Genitalia, a New Epidemic," Richard Feinstein, M.D., Miami.

"Angiographic Procedures in Acute Gastrointestinal Bleeding," Sheldon A. Roen, M.D., Chief, Cardiac and Vascular Radiology, Mt. Sinai Hospital, Miami Beach, and Assistant Professor of Radiology, University of Miami School of Medicine.

"Current Management of Squamous Cancer of the Anorectum," Stuart H. Q. Quan, M.D., Associate Professor of Surgery, Cornell Medical School, and Attending Surgeon, Colon and Rectal Service, Department of Surgery, Memorial Hospital, New York, N.Y.

Adjournment

SECTION ON RADIOLOGY AND ENDOCRINOLOGY

(Co-sponsored by Florida Radiological Society and Florida Endocrine Society)

Friday—2:00 p.m. to 5:30 p.m.

Everett N. McCormick, M.D., Jacksonville

Yank D. Coble Jr., M.D., Jacksonville
Program Co-Chairmen

Welcome and Opening Remarks—Paul A. Mori, M.D., President, Florida Radiological Society, Jacksonville; and Eugene T. Davidson, M.D., President, Florida Endocrine Society, Lakeland.

I. Neuroendocrinology

"Evaluation of the Pituitary and Para Sellar Regions," O. Frank Agee, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville.

"Endocrinological Aspects" (Panel)
Eugene Davidson, M.D., Lakeland
Robert Farese, M.D., Tampa
William Thomas, M.D., Gainesville
Larry Fishman, M.D., Miami

Discussion

Break

II. Evaluation of the Thyroid

"Nuclear and Ultrasonic Imaging," Fuad Ashkar, M.D., Associate Professor of Radiology and Assistant Professor of Medicine, University of Miami School of Medicine, Miami.

"Endocrinological Aspects," Robert Farese, M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa.

Discussion

Break

III. Skeletal System

"Metabolic Bone Disease," William Thomas, M.D., Professor of Medicine, University of Florida College of Medicine, Gainesville.

Discussion

Break

IV. Hypertension

"Radiological Evaluation of the Hypertensive Patient," Juri Kaude, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville.

"Endocrinological Considerations," Larry Fishman, M.D., Professor of Medicine, University of Miami School of Medicine, Miami.

Discussion

Adjournment

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)

Friday—4:00 p.m. to 5:00 p.m.

Daniel L. Seckinger, M.D., Miami
Program Chairman

"Metabolism of the Kidney in Vivo," Robert F. Pitts, M.D., Ph.D., Research Professor of Renal Medicine and Physiology, University of Florida College of Medicine, Gainesville.

Adjournment

SECTION ON PEDIATRICS AND ORTHOPEDIC SURGERY

(Co-sponsored by the Florida Pediatric Society and Florida Chapter of the American Academy of Pediatrics and Florida Orthopedic Society)

Friday—2:00 p.m. to 5:20 p.m.

George A. Richard, M.D., Gainesville

Charles A. Mead Jr., M.D., Jacksonville
Program Co-Chairmen

SESSION I—"Medical Management of Osteomyelitis and Septic Arthritis in Infants, Children and Adolescents"

Moderator: Robert P. Keiser, M.D., Clinical Professor of Orthopedics, University of Miami School of Medicine, Miami.

"The Medical Approach," Philip Glade, M.D., Professor of Pediatrics and Director, Division of Pediatric Infectious Disease and Immunology, University of Miami School of Medicine, Miami.

"The Surgical Approach," Newton C. McCollough, M.D., Associate Professor of Orthopedics and Rehabilitation and Director, Rehabilitation Center, University of Miami School of Medicine, Miami.

Discussion

SESSION II—"Muscular Dystrophy and Associated Conditions"

Moderator: Joseph G. Matthews, M.D., Chairman, Department of Orthopedic Surgery, Orange Memorial Hospital, Orlando.

"The Medical Approach," Philip A. Singer, M.D., Assistant Professor of Medicine, Neurology Division, University of South Florida College of Medicine, Tampa.

"The Surgical Approach," Merlin Anderson, M.D., Associate Professor of Orthopedic Surgery, University of South Florida College of Medicine, Tampa.

Discussion

Break

SESSION III—"Sports Medicine"

Moderator: Philip O. Lichtblau, M.D., Chief of Orthopedic Surgery, St. Mary's Hospital, West Palm Beach.

"Medical Management," Richard B. Shaara, M.D., Director of Student Health Affairs, University of Florida College of Medicine, Gainesville.

"The Role of the Orthopedic Surgeon," Willlam C. Allen, M.D., Associate Professor of Orthopedic Surgery, University of Florida College of Medicine, Gainesville.

Discussion

SESSION IV—"Idiopathic Scoliosis"

Moderator: Joseph C. Flynn, M.D., Director of Scoliosis Screening Program, Orlando.

"Screening, Early Evaluation and Treatment," Robert W. Bright, M.D., Assistant Professor of Orthopedics and Pediatrics and Director of Children's Orthopedics, Department of Orthopedic Surgery, University of Florida College of Medicine, Gainesville.

Discussion

Adjournment

SATURDAY MORNING—MAY 8

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)

Saturday—8:45 a.m. to 12:00 noon

Rafael A. Penalver, M.D., Miami
Program Chairman

Welcome and Introduction of Speakers—Rafael A. Penalver, M.D., Director, Office of International Medical Education, University of Miami School of Medicine, and President, Florida Society for Preventive Medicine.

"The National Conference on Preventive Medicine—Summaries and Recommendations," Irving R. Tabershaw, M.D., President, American College of Preventive Medicine, Berkeley, Calif.

"Cardiovascular Risk Factor Intervention," George Chraistakis, M.D., M.P.H., Director, Cardiovascular Risk Factor Reversal Program, Delray Beach, Fla.; and C. L. Brumback, M.D., M.P.H., Director, Palm Beach County Health Department, West Palm Beach.

"East Coast Migrant Entitlement," J. T. Howell, M.D., M.P.H., Secretary-Treasurer, Florida Society for Preventive Medicine, Palm Springs, Fla.; and Mr. Eugene Boneski, M.S., Migrant Coordinator of the East Coast, Migrant Entitlement Project, West Palm Beach.

"Manganese Poisoning in Florida," Rafael A. Penalver, M.D., Miami.

Adjournment

SECTION ON PEDIATRIC CARDIOLOGY

(Co-sponsored by Florida Association of Pediatric Cardiologists)

Saturday—9:00 a.m. to to 11:30 a.m.

Henry Gelband, M.D., Miami
Program Chairman

Introduction—Henry Gelband, M.D., Chairman

"Cardiac Catheterization in Florida, 1975: Update"

Benjamin E. Victorica, M.D., Gainesville

Sidney Brodsky, M.D., St. Petersburg

Otto Garcia, M.D., Miami

Lloyd Hoffman, M.D., Pensacola

David Ruschaupt, M.D., Jacksonville

Discussion

"The Ideal Pediatric Cardiac Catheterization Laboratory: Today and Tomorrow," L. Jerome Krovetz, M.D., Professor of Pediatric Cardiology, University of Virginia School of Medicine, Charlottesville, Va.

Discussion

Adjournment

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)

Saturday—8:00 a.m. to 10:00 a.m.

Walter R. Gilbert, M.D., Jacksonville
Program Chairman

"Retinopathy of Prematurity," John T. Flynn, M.D., Associate Professor of Ophthalmology, University of Miami School of Medicine, Miami.

"Congenital Cataracts," Matthew Rabinowicz, M.D., Assistant Professor of Ophthalmology, University of Florida College of Medicine, Gainesville.

Adjournment

SECTION ON ALLERGY

(Co-sponsored by Florida Allergy Society)

Saturday—8:30 a.m. to 12:30 p.m.

Heinz J. Wittig, M.D., Gainesville
Program Chairman

"Precipitate Allergens in Immunotherapy," Samuel C. Bukantz, M.D., Professor of Internal Medicine, and Chief of Allergy and Clinical Immunology, College of Medicine, University of South Florida, and Veterans Administration Hospital, Tampa.

Discussion

"Provocative Testing and Neutralization Therapy," Douglas H. Sandberg, M.D., Professor of Pediatrics, and Co-Director of the Clinical Research Center, University of Miami School of Medicine, Miami.

Discussion

"Controversial, Diagnostic and Therapeutic Techniques in Allergy," Richard F. Lockey, M.D., Assistant Professor of Internal Medicine, College of Medicine, University of South Florida, and Veterans Administration Hospital, Tampa.

Discussion

"Approved Diagnostic and Therapeutic Procedures in Allergy for Third Party Payments," Benjamin A. Johnson, M.D., Associate Medical Director, Blue Cross and Blue Shield of Florida, Jacksonville.

Discussion

Adjournment

SECTION ON PEDIATRIC SURGERY

(Co-sponsored by Florida Association of Pediatric Surgeons)

Saturday—9:30 a.m. to 12:15 p.m.

Burton H. Harris, M.D., Jacksonville
Program Chairman

Welcome—H. Warner Webb, M.D., President, Florida Association of Pediatric Surgeons, Jacksonville.

Introduction of Guest Speaker—Burton H. Harris, M.D., Clinical Assistant Professor, Pediatric Surgery, University of Florida College of Medicine (JHEP), Jacksonville.

"New Thoughts on Jejuno-Ileal Atresia," Robert J. Touloukian, M.D., Associate Professor of Surgery and Pediatrics, and Chief, Division of Pediatric Surgery, Yale University College of Medicine, New Haven, Conn.

"Microsurgical Instruments in Pediatric Surgery," Ralph L. Swank, M.D., Tampa.

"Pectus Excavatum," (Film)—William T. Brown, M.D., Clinical Assistant Professor of Pediatric Surgery, University of Miami School of Medicine, Miami.

Coffee Break

"Infantile Achalasia," Farhart Moazam, M.D.; Bradley M. Rodgers, M.D., Assistant Professor of Surgery and Pediatrics; and James L. Talbert, M.D., Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville.

"A New Tumor of the Testis," Philip Hinton, M.D.; H. Warner Webb, M.D., Clinical Assistant Professor, Pediatric Surgery; Albert H. Wilkinson Jr., M.D., Clinical Associate Professor, Pediatric Surgery; and Burton H. Harris, M.D., Clinical Assistant Professor, Pediatric Surgery, University of Florida College of Medicine (JHEP), Jacksonville.

"Thoracoscopy in the Diagnosis of Pneumocystis Carinii Pneumonia," Bradley M. Rodgers, M.D., Assistant Professor of Surgery and Pediatrics; and James L. Talbert, Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville.

"Mesenteric Lymphangiectasis with Chylous Ascites," Adrian R. Jensen, M.D., Merritt Island.

"Unusual Chest Wall Lesions in Children," Luis Felipe Mencia, M.D., Coral Gables.

"Bilateral Ovarian Granulosa Cell Tumors in Infancy," John I. Hollenbeck, M.D., Bradley M. Rodgers, M.D., Assistant Professor of Surgery and Pediatrics; and James L. Talbert, M.D., Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville.

Adjournment

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons, and Florida Association of General Surgeons)

Saturday—9:00 a.m. to 11:00 a.m.

Martin G. Gould, M.D., Ft. Pierce
Program Chairman

"Surgical Manpower: Supply and Demand" (Panel)

(Speakers to be announced)

Adjournment

SECTION ON NEUROSURGERY

(Co-sponsored by Florida Neurosurgical Society)

Saturday—9:00 a.m. to 11:15 a.m.

Hubert A. Aronson, M.D., Miami
Program Chairman

"Intra-Cranial Pressure Monitoring," Leon Gilner, M.D., University of Miami School of Medicine, Department of Neurosurgery, Miami.

"Intra-Cranial Pressure Monitoring," John Vries, M.D., University of Florida College of Medicine, Department of Neurosurgery, Gainesville.

"Cranial-Facial Reconstruction," Jack Maniscalco, M.D., University of Florida College of Medicine, Department of Neurosurgery, Gainesville.

"Micro-Neurosurgical Education at the University of Florida," Albert L. Rhoton Jr., M.D., Professor and Chief, Neurological Surgery, University of Florida College of Medicine, Gainesville.

Individual Case Reports—By members of the Florida Neurosurgical Society

Adjournment

SECTION ON RADIOLOGY

(Co-sponsored by Florida Radiological Society)

Saturday—8:30 a.m. to 11:00 a.m.

Everett N. McCormick, M.D., Jacksonville
Program Chairman

Welcome and Opening Remarks—Lawrence Muroff, M.D., President of the Florida Association of Nuclear Physicians, Tampa.

"Update—Clinical Abdominal Ultrasound," Aldo Serafini, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

Break

"Update—Nuclear Imaging," August Miale Jr., M.D., Professor of Radiology, University of Miami School of Medicine, Miami.

Break

Report from the Florida Association of Nuclear Physicians —Lawrence Muroff, M.D.

Adjournment

SECTION ON DERMATOLOGY

(Co-sponsored by the Florida Society of Dermatology)

Saturday—8:30 a.m. to 12:30 p.m.

Gerald D. Weinstein, M.D., Miami
Program Chairman

Resident Research Presentations

Invited Guest Speaker (To be Announced)

Intermission

Resident Research Presentations

Invited Guest Speaker (To be Announced)

Round-table Discussion with Audience Participation

Adjournment

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)

Saturday—9:00 a.m. to 12:00 noon

Jack D. Norman, M.D., Miami
Program Chairman

Current Topics in Plastic and Reconstructive Surgery—by Residents in Plastic and Reconstructive Surgery at the University of Miami School of Medicine.

Current Topics in Plastic and Reconstructive Surgery—by Members of the Florida Society of Plastic and Reconstructive Surgery.

Guest Lecture—(To be Announced)

Adjournment

SECTION ON PEDIATRICS

(Co-sponsored by Florida Pediatric Society and Florida Chapter of the American Academy of Pediatrics)

Saturday—8:30 a.m. to 12:15 p.m.

George A. Richard, M.D., Gainesville
Program Chairman

SESSION I

Moderator: Julia R. St. Petery, M.D., Program Staff Director, Children's Medical Services, Tallahassee.

"The Normal and Abnormal Development of the Teeth," Carroll G. Bennett Jr., D.D.S., Professor and Chairman, Department of Pediatric Dentistry, University of Florida, Gainesville.

Discussion

"Oral Pathology as an Indicator of Local and Systemic Disease," George A. Colmer, D.D.S., Assistant Professor of Pediatrics and Oral Biology, University of Miami, Miami.

Discussion

SESSION II

Moderator: Bernard F. O'Hara, M.D., Chief of Staff, St. Mary's Hospital, West Palm Beach.

"The Clinical Significance of Post-auricular, Cervical and Supraclavicular Lymphadenopathy," Jan Judisch, M.D., Associate Professor of Pediatrics and Chief of Pediatric Hematology, University of South Florida College of Medicine, Tampa.

Discussion

"The Current Approach to the Treatment and Follow-up of Otitis Media," James Hallock, M.D., Associate Professor of Pediatrics and Chief of the Pediatric Ambulatory Care Center, University of South Florida College of Medicine, Tampa.

Discussion

Break

"The Diagnosis and Treatment of Pharyngitis," Kenneth Flicker, M.D., Clinical Assistant Professor of Pediatrics, University of Miami School of Medicine, Miami.

Discussion

SESSION III

Moderator: Gordon R. Heath, M.D., Alternate State Chairman, Florida Pediatric Society, Lakeland.

"The Evaluation and Treatment of Diseases of the Scalp and Hair," Robert H. Cohan, M.D., Clinical Assistant Professor, Pensacola Education Program, University of Florida College of Medicine.

Discussion

"The Management of Nasal Problems in Pediatrics," John Mangos, M.D., Professor of Pediatrics and Chief of Pulmonary Disease and Cystic Fibrosis, University of Florida College of Medicine, Gainesville.

Discussion

Adjournment

SECTION ON GASTROENTEROLOGY AND ENDOCRINOLOGY

(Co-sponsored by Florida Gastroenterologic Society and Florida Endocrine Society)

Saturday—8:30 a.m. to 12:30 p.m.

William G. Baker Jr., M.D., St. Petersburg
Program Chairman

Introduction—William G. Baker Jr., M.D., St. Petersburg

"Serendipity and Pancreatic Cholera," John Verner, M.D., Watson Clinic, Lakeland.

"Gastrin and Differential Diagnosis of Hypergastrinemia," Walter Trudeau, M.D., Chief, Gastrointestinal Section, University of South Florida VA Hospital, Tampa.

"Insulin Regulation and Clinical Significance," Ann Lawrence, M.D., Professor of Medicine, University of Chicago, Chicago, Ill.

Discussion

Break

"Secretin and CCK-PZ and Hormonal Interrelationship and Control of Digestion," Martin Kaiser, M.D., Arvey Rogers, M.D., and Jaime Barkin, M.D., Department of Medicine, University of Miami School of Medicine, Miami.

(Continued on page 156)

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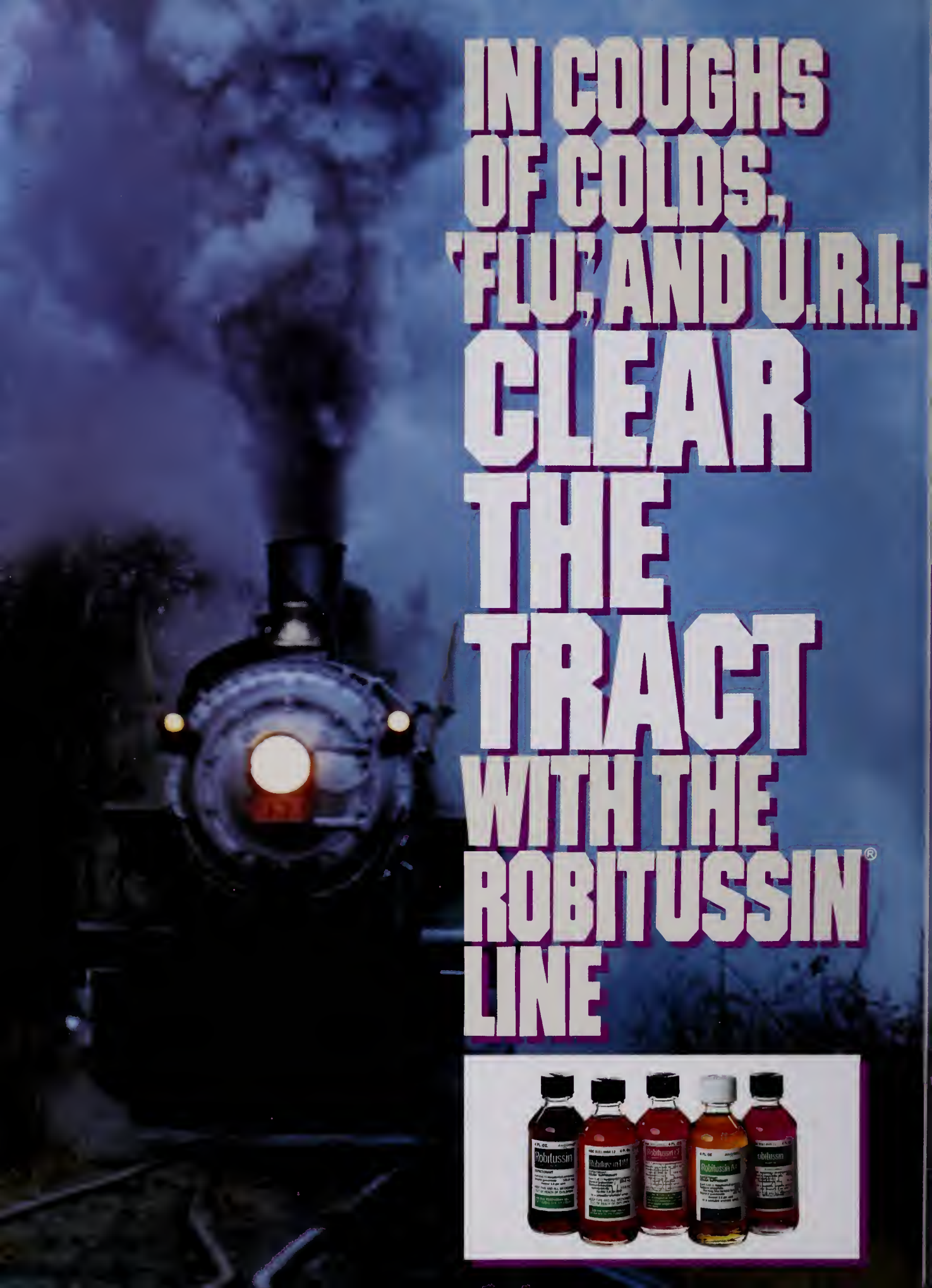
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Decongests nasal passages and sinus openings as it helps relieve coughs

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For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives... accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The William Mason (1856)

Discussion

Adjournment

SECTION ON ORTHOPEDIC SURGERY

(Co-sponsored by Florida Orthopedic Society)

Saturday—8:30 a.m. to 12:00 noon

Charles A. Mead, M.D., Jacksonville
Program Chairman

"Tennis Elbow: A Biomechanical Approach," Arthur M. Bernhang, M.D., Huntington, N.Y.

"Review of 126 Consecutive Nailings of Displaced Hip Fractures with Massie Nail," Fred C. Tucker, M.D., Clearwater.

"Injuries to the Elbow," Arthur Pearl, M.D., Miami.

Coffee Break

"Medical Advisory Committee Report," Francis T. Holland, M.D., Tallahassee.

"Fingertip Coverage," Massoud Massoumi, M.D., West Palm Beach.

"Recurrent Posterior Dislocation of the Hip," James F. Richards, M.D., Orlando.

"High Resection of the Common Peroneal Nerve in Below the Knee Amputations," Richard G. Dedo, M.D., and Robert O. Pohl, M.D., Jacksonville.

Adjournment

SATURDAY AFTERNOON—MAY 8

SECTION ON ENDOCRINOLOGY

(Co-Sponsored by Florida Endocrine Society)

Saturday—1:00 p.m. to 2:45 p.m.

Yank D. Coble Jr., M.D., Jacksonville
Program Chairman

"Neuroendocrinology," Ann Lawrence, M.D., Professor of Medicine, University of Chicago, Chicago, Ill.

"Hypothalamic Pituitary Gonadal Relationships," Griff Ross, M.D., Clinical Director and Chief of Reproductive Research Branch, National Institute of Child Health and Human Development, Bethesda, Md.

Discussion

Adjournment

Thanks to Contributors to Special Issue on Dermatology

The Journal of the Florida Medical Association, its Editors and Special Guest Editors, Drs. Charles C. Dugan and Morris Waisman wish to express their gratitude to the following contributors who made possible the publication of a Special Dermatology Issue in January 1976. The publication of this issue would not have been possible without the support of these contributors:

American Cancer Society

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Florida Society of Dermatology

Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Emergency Medical Care, edited by J. Clifford Findeiss, M.D. 333 Pages. Illustrated. Price $17.95. New York, Intercontinental Medical Book Corporation, 1974.

To my surprise on receiving this book for review, the Emergency Medical Care turns out not to be a manual, but a symposia of talks given at the first annual meeting of the combined American College of Emergency Physicians and the Emergency Department Nurses Association in combination with the University of Miami. This was a meeting which apparently got into publication in 1974 and the book is the text of speeches given by various physicians at this meeting. The book is therefore not a routine (how-to) manual but is rather a series of generalized talks on certain specific topics divided up into several headings such as surgical emergencies, medical emergencies, psychiatric emergencies, emergency in medical services and community planning with such diverse topics as health care during the 1972 National Political Conventions and the EMP, his training and future. Many of these talks are very well delivered, and contain a goodly amount of excellent information, however, my chief criticism of this book is that it is extremely poor in manner of printing. The copy that I received, in the first surgical section, had many pages that were almost impossible to read with diagrams that were impossible to read. The print was either light or blurred and the reproductions of things such as x-rays were totally unable to be properly visualized. The paper was of exceptionally poor quality and even some of the proofreading was poor. This book is one of value for the emergency room physician, but only certain particular headings would be of value to the specialist or generalist who uses the emergency room frequently.

I would compliment Dr. Findeiss on his selection of speakers as the topics were exceptionally well presented. They do, however, hit a wide diversity of subjects. As to reinforce the previous statements, it is a book that would go well in a hospital library, but would not be of use throughout its entirety to the physician not dealing entirely in the emergency room care.

It was, however, quite interesting for me to read it throughout, and I do feel I acquired a goodly bit of knowledge from the experience.

Joel P. Kallan, M.D.
Miami

Symposium on Reconstruction of the Auricle by Radford C. Tanzer, M.D. and Milton T. Edgerton, M.D. 312 Pages. 611 Illustrations. Price $42.50. St. Louis, The C. V. Mosby Company, 1974.

This symposium is divided into three distinct units that cover entirely different surgical and psychological problems. They must therefore be considered separately in the review of this book. The first section is a discussion of congenital deformities of the auricle and their correction. There is a good review and description of various surgical problems. The remainder of the articles on surgical technique involve discussion of cartilage versus sialastic molds for surgical reconstruction. One of the better discussions concerns size and growth of the auricle in relationship to the rest of the facial structures as well as embryonic development. One of the basic short comings of the first chapter was a very superficial discussion of many of the psychological problems these children face because of their deformity and the many surgical procedures they undergo. Very little time and space was given to the use of a prosthesis instead of reconstruction. The problem of construction of an ear canal associated with middle ear construction was only superficially discussed although this was not the primary objective of the symposium. It did bring up some of the conflicting and controversial subjects and views in this field.

Part two was devoted to traumatic deformities of the auricle. In general this section was well written and the discussions following the paper were very good. There were several very ingenious methods of reconstruction depicted and well illustrated. The papers on the avulsion of the ear were well illustrated and the guidelines for handling the avulsed ear were well grounded.

The third part was titled "Associated Congenital Facial Deformities." These involved fairly marked deformities and after a thorough review one can only state that this is not a problem that should be handled by the general plastic surgeon or cosmetic surgeon who usually sees these infrequently. The problems are multiple requiring a complete team approach consisting minimally of a plastic surgeon, oral surgeon, an orthodontist.

The total reconstruction of the auricle is a difficult and time consuming procedure that is not seen

frequently. This should be done at centers or by a few people who are particularly interested and have extensive experience in this reconstructive procedure. The second part of the book is well worth the time for studying the different surgical techniques used by the various authors in injuries to the ear. This book is valuable for use as a reference book and should be available in teaching institutions or large medical libraries for residents anad practicing plastic surgeons.

Stephen E. Howery, M.D.
Winter Park

Review of Physiological Chemistry, (15th Edition) by Harold A. Harper, Ph.D. 570 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1975.

The 15th Edition (1975) of this book is 27 pages longer than the 14th Edition which I reviewed last year. The editor is still Harold A. Harper of the University of California School of Medicine. The collaborators are the same. New is Dr. Waldo E. Cohn of the Office of Biochemical Nomenclature of the National Research Council, who has helped to make the book conform as much as possible to the new nomenclature.

Advancing knowledge makes it necessary to give prominence to recent studies, while making the book a new concise source of information in contrast to standard textbooks.

There are 22 chapters, as in the previous edition, which deal with the chemistry of cells, body systems, and physiological activities. An Appendix contains brief explanations of General, Physical, and Organic Chemistry, along with Abbreviations and Alternative Terminology frequently in Physiological Chemistry.

The 15th edition goes into a bit more depth than the 14th edition in some subjects such as Vitamin A, Prostaglandins, and Cyclic AMP.

In general, I would recommend the book for the busy practitioner who wants to get a quick review, from time to time, on some aspect of physiological chemistry. At the end of each chapter there is a bibliography for more extensive indepth searching. The price has not changed in recent years for the book, still being $10.00, which is a very reasonable figure in this age of escalating book costs.

Perry A. Sperber, M.D.
Daytona Beach



Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

The Vitamin C Cookbook by Cory SerVaas, M.D. and Walter Mathews. 154 Pages. Price $6.95. Garden City, New York, Doubleday and Company, Inc., 1975.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Genetic Screening Programs, Principles, and Research by Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences. 388 Pages. Washington, D.C., National Academy of Sciences, 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

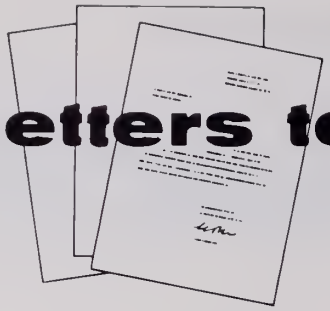
Vectorcardiography, Second Edition by Louis Lemberg, M.D. and Agustin Castellanos, Jr., M.D. 260 Pages. Illustrated. Price $16.00. New York, Appleton-Century-Crofts, 1975.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.-O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

The Homosexual Matrix by C. A. Tripp, 314 Pages. Price $10.00. New York, McGraw-Hill Book Company, 1975.

Emergency Management of the Critical Patient, Vol. 2, by J. Clifford Findeiss, M.D. 280 Pages. Price $17.95, Stratton Intercontinental Medical Book Corporation, New York, 1975.



Letters to the Editor

To the Editor: There is no doubt in my mind that limitation of contingency fees is essential if we are to reduce malpractice premiums. For those of you who may not have read an article in the September 15th issue of Medical Economics, there was an excellent treatise entitled "Expert Medical Witness" written by a physician who had testified at many trials. He states that "the contingency fee, in conjunction with an insurance system that is very willing to pay several thousand dollars to an attorney and his client for an agreement not to sue, encourages most lawyers to take cases with little merit so that they can, at least, get bread and butter settlements from insurance carriers." He further describes the "Perpetual Motion Theory." Under this theory a lawyer can prolong a case for which he knows he has a good chance of getting paid by keeping a running tab of every minute spent on the case adding up to hundreds of hours. He also notes that judges and juries ordinarily have absolutely no idea about the medical details of a given case.

I have recently introduced HB-2395 in an attempt to reduce contingency fees. It makes little sense to me for a patient to receive as little as 16¢ out of a dollar in cases of true negligence when the case is settled for some astronomical amount of monies.

Recently, the Florida Bar's Board of Governors has made a token recommendation for limitation of contingency fees, varying from 33½% to 45% up to the first $500,000 with a limitation of 25% of any amount over that. This is the Bar's attempt for regulating itself to control this abuse and it would appear to me to be a rather weak attempt.

If HB-2395 is to become law, I will require your assistance in attempting to achieve final passage during the 1976 legislative session. There is no doubt in my mind that without some meaningful regulation of this sort, we will experience great difficulty in securing any major insurance company to return to Florida to write malpractice insurance at reasonable rates.

David J. Lehman
Representative, District 97

To the Editor: The article, "Lobbying" in the **Washington Post,** reprinted in the **Miami Herald,** I hope was read by many of our doctors. The non-medical readers will find the factualism to be cynically critical of American physicians' concern in their health problems.

This article reveals the mesalliance of the AMA with AMPAC, and directly through the latter, with insurance companies, the drug industries and legislators opposing National Health Insurance and increased federal funds for health programs. Consider if our bed-fellowship with insurance companies has given doctors fair consideration in malpractice insurance.

The AMA is now seeking increased dues for their operations—like paying former Governor Ronald Reagan for his vocal talents on a series of records for physicians' wives to play before groups—"Operation Koffee Klatch"—to oppose Medicare. In retrospect, what did the FMA dues increase pay for or will be used for?—To invite speakers like Senator Goldwater to our annual meeting? Ponder this—What if the FMA had invited a Senator John Kennedy in that period of recuperation from McCarthyism?

Don't delude the membership that the House of Delegates democratically elects officials, with miniscule opposition at the yearly meetings, who reflect the opinion of a similar preponderant majority of the physicians of Florida, or more accurately the health needs of the people. If meetings of the DCMA are examples of democratic roots which flower into House of Delegates representation, these hasn't been a quorum present, upon challenge, for at least the past year, so that no official action could be taken.

There is much more to be discussed, particularly if the malpractice disease has any relativity. As a starter, full and open disclosure should be made of specified salaries, employees and authorized expenditures, and bank balances. All publications should be readily available for opposing and alternative views. Not least, local society meetings should prepublicize the agenda and have open and lively discussions with invited speakers juxtaposed to the one

wing—of AMA leadership—the right wing by starboard position, but not by such measures as Social Security and Medicare.

Harry E. Beller, M.D.
Miami

Dear Dr. Beller:

Although I will defend to the death your right to have your say in The Journal, I disagree with some of the points in your letter.

In the first paragraph, only something over 2,000 physicians in southern Florida may read the Miami Herald so this is confusing to those other FMA members who do not read it.

So, I don't understand the reference about the alliance of AMA with AMPAC. Reading the American Medical News and everything else I can that comes across my desk, I have not seen anything that would make this clear, and I suspect that many other readers might be in the same boat.

In reply to your question concerning use of money obtained from the FMA dues increase, $2000 each month goes to help defray the cost of this Journal, for advertising no longer pays for its publication or the rising cost of paper, ink and printing. The many other costs of running FMA are gone over by the Executive Committee of the Board of Governors to eliminate anything not in the best interest of the organization.

Finally, I agree with you that officers of the FMA plus the House of Delegates are a small vocal minority of the medical association; nevertheless, they are those who take time from their practice to attend meetings, serve on committees, to formulate policies and make decisions and, if they have the ability, end up as being elected our officials. Any of the rank and file members of the FMA can use effectively his influence to change the delegates, the officers or the rules by taking the time through the proper channels.

Thanks for writing to the Editor. Only from letters by our readers can he determine whether his selection of articles for insertion in The Journal has been good or bad. Also, it is a platform from which one can comment on any activity of the Association with which he disagrees. I would urge you to continue writing on anything with which you disagree. At the same time, include recommendations as to how corrections can be carried out. Space permitting, the Editor will publish those worthy of reprinting.

Clyde M. Collins, M.D.
Associate Editor

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Deaths

Andrews, Edwin H., Cedar Key; born 1899; Indiana University, 1927; member AMA; died October 29, 1975.

Barton, Maurice Arthur, St. Petersburg; born 1896; Boston College of Physicians and Surgeons, 1929; member AMA; died October 16, 1975.

Belgorod, Samuel H., Fort Myers; born 1910; College of Physicians and Surgeons-Columbus University, 1935; member AMA; died February 10, 1975.

Blair, William M., West Palm Beach; born 1888; University of Alabama, 1910; member AMA; died date unknown.

Brede, Edward H., Fort Lauderdale; born 1934; George Washington University, 1960; member AMA; died date unknown.

Cooper, Sam Marshall, Ft. Walton Beach, born 1912; University of Tennessee, 1937; member AMA; died October 2, 1975.

Goodman, Bernard, Miami, born 1910; Temple University Medical School, 1935; member AMA; died October 9, 1975.

Goodnow, Chester L., Chatham, Massachusetts; born 1910; Tufts, 1934; member AMA; died December 7, 1975.

Griffin, George W., Alexandria, Louisiana; born 1915; Louisiana State University, 1938; member AMA; died December 12, 1975.

Halpern, Jesse O., Miami Beach; born 1911; University of Michigan, 1936; member AMA; died November 9, 1975.

Hauss, John Frederick, Miami Beach, born 1912; Ohio State University, 1937; member AMA; died September 27, 1975.

Hoover, Russell D. D., Palm Beach; born 1915; Temple University, 1941; member AMA; died November 11, 1975.

Jones, Thee Alan, Orlando, born 1899; University of Tennessee, 1927; member AMA; died October 6, 1975.

Manson, Plumer J., Miami; born 1896; Medical College of Georgia, 1922; member AMA; died November 26, 1975.

Mills, Richard Ambrose, Ft. Lauderdale, born 1898; Ohio State Medical School, 1925; member AMA; died September 28, 1975.

O'Connor, James B., Tallahassee; born 1908; University of Georgia, 1935; member AMA; died November 21, 1975.

Templeton, Earl R., Hollywood; born 1891; Syracuse Medical School, 1920; member AMA; died October 30, 1975.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

ound useful in the management of vertigo* associated with ases affecting the vestibular system.

an relieve nausea and vomiting often associated with vertigo.*

sual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

lso available as Antivert (meclizine HCl) 12.5 mg. scored ets, for dosage convenience and flexibility.

ntivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for sea, vomiting and dizziness associated with motion sickness.

F SUMMARY OF PRESCRIBING INFORMATION

NDICATIONS. Based on a review of this drug by the National Academy of ences—National Research Council and/or other information, FDA has classified indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with otion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the stibular system.

Final classification of the less than effective indications requires further vestigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS



Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

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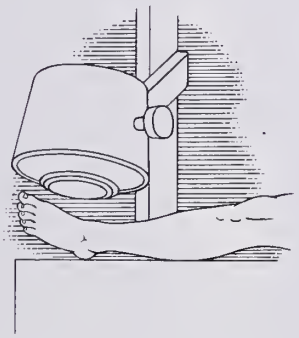
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For a brief summary of prescribing information, please see following page.

addendum

MSD
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Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

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helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes; purpura.

Ear Reactions: Hearing disturbances, deafness, tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Note: In patients receiving probenecid, plasma levels of indomethacin are likely to be increased.

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ACCREDITED BY THE J. C. A. H.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

FEBRUARY

Update Gastroenterology: 1975, Feb. 1-2, Americana Hotel, Miami Beach*

Practical Modern Neurology, Feb. 2-6, Hotel Fontainebleau, Miami Beach*

Practical Problems in Clinical Cardiology, Feb. 2-6, Hyatt House, Miami Beach. For information: Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 2-7, Americana Hotel, Miami Beach*

Tenth Annual Symposium on Cosmetic Surgery, Feb. 5-7, Cedars of Lebanon Health Care Center, Miami. For information: Cedars of Lebanon Health Care Center, 1321 N.W. 14th St., Miami 33125

Sex Counseling for the Physician, Feb. 5-7, Sheraton Towers, Orlando**

Recent Advances in Cardiopulmonary Care II, Feb. 6-7, Holiday Inn—Lido Beach, Sarasota. For information: Sarasota Memorial Hospital, 1901 Arlington St., Sarasota 33579

Postgraduate Course in Clinical Allergy, Feb. 8-13, Sonesta Beach Hotel, Key Biscayne*

Second Annual USF Cancer Seminar, Feb. 14, Ft. Harrison Hotel, Clearwater+

Symposium in Perinatology, Feb. 18-20, University of Miami School of Medicine, Miami*

Immunological Mechanisms of Disease, Feb. 18-20, Hilton Hotel, Gainesville**

Medical Hypnosis for the Practicing Physician, Feb. 20, Aboard the SS Monarch*

Second Fred J. Woods Lecture Series, Feb. 21, St. Joseph's Hospital, Tampa. For information: Ralph Jensen, M.D., 3001 W. Buffalo Ave., Tampa 33607

Neurology for Psychiatrists, Feb. 23-27, Hotel Fontainebleau, Miami Beach*

"Hematology/Oncology Basic Review and Update," Feb. 26-29, Amelia Island Inn, Amelia Island, Florida. For information: JHEP, 655 West 8th St., Jacksonville 32209.

Workshop—Infectious Disease in Everyday Practice, Feb. 28-Mar. 4, Amelia Island. For information: J. A. Hinckley, P.O. Box 11083, Richmond, Va. 23230

Management of Nonsurgical Medical Emergencies, Feb. 25-27, University of South Florida, Tampa+

New Trends in Ocular Treatment, Feb. 25-29. Fontainebleau Hotel, Miami Beach. For information, Olga M. Ferrer, M.D., 1889 S. Bayshore Drive, Miami 33133.

Cancer Conference: Diagnosis and Management of Ovarian Carcinoma, Feb. 27, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

▸**Contemporary Surgery,** Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Medicine & Surgery, 30 N. Michigan Ave., Chicago 60602

▸**Contemporary Ophthalmology,** Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Ophthalmology, 30 N. Michigan Ave., Chicago 60602

▸**Contemporary Medicine 1976,** Feb. 29-Mar. 5, Americana Hotel, Miami Beach. For information: Am. Soc. Contemporary Medicine & Surgery, 30 N. Michigan Ave., Chicago 60602

▸**Selected Topics in Cutaneous Medicine,** Feb. 29-Mar. 6, Diplomat Hotel, Hollywood, Florida. For information: N.W. Dermatologic Soc., 1150 David Whitney Bldg., Detroit, Michigan 48226

MARCH

Infant Nutrition, Mar. 4-5, University of South Florida, Tampa+

Selected Topics in Urology, Mar. 4-6, Hilton Hotel, Gainesville**

Fifth Annual Postgraduate Seminar in Dermatology, Mar. 5-7, Hyatt House, Miami Beach*

Second Annual Pediatric Surgical Postgraduate Course, Mar. 10-12, Deauville Hotel, Miami Beach. For information: William T. Brown, M.D., Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155.

"Cardiology Update—1976," Mar. 12-13, Amelia Island Inn, Amelia Island, Florida. For information: JHEP, 655 West 8th St., Jacksonville 32209.

Head and Neck Cancer Seminar, Mar. 13, Ramada Inn, Jacksonville Beach. For information: Nelson Goldman, M.D., 3599 University Boulevard S., Jacksonville 32218.

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

▸ National meetings being held in Florida.

Eighth Teaching Conference in Clinical Cardiology, Mar. 17-20, Sheraton Four Ambassadors Hotel, Miami*

Annual Suncoast Trauma Seminar, Mar. 18-20, Holiday Inn, Tampa+

"Ninth Annual Instructional Course on Surgery of the Hand," Mar. 19-21, University Hospital, Jacksonville. For information: JHEP, 655 West 8th St., Jacksonville 32209

Advanced Life Support: The Fourth Annual Postgraduation Seminar in Emergency Medicine, Mar. 19-22, Americana Hotel, Miami Beach. For information: Registrar, 1976 PGS, 1919 Beachway Rd., Jacksonville 32207

6th Annual Special Procedures Seminar: How and Why We Do It (Radiology), Mar. 21-24, Hyatt House, Miami Beach*

Fourteenth Clinical Radiology Seminar "How and Why we do Specific Radiology Procedures," Mar. 24-28, Hyatt House, Miami Beach*

Inflammatory Bowel Disease, Mar. 25, University of South Florida, Tampa+

Seventh Annual Topics in Internal Medicine, Mar. 25-27, Gainesville Hilton, Gainesville**

Topics in Adolescent Medicine for the Practicing Physician, Mar. 26, Aboard the SS Monarch*

Cancer Conference: Management of Bone Tumors, Mar. 26, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Diagnosis and Management of Airways Disease, Mar. 27-28, University of South Florida College of Medicine Medical Center, Tampa+

Post-Convention Seminar: Anatomic-Pathologic Correlations in Pulmonary & Gastrointestinal Diseases, Mar. 28-31, (Cruise)*

Diagnosis and Management of Obstructive Airways Disease, Mar. 29-30, University of South Florida, Tampa+

Renal Disease and Hypertension, Mar. 31-Apr. 3, Americana Hotel, Bal Harbour*

Symposium in Perinatology, Mar. 31-Apr. 3, Sonesta Beach Hotel, Key Biscayne*

Renal Disease & Hypertension, Mar. 31-Apr. 3, Americana Hotel, Miami Beach*

APRIL

Spring Symposium in Intensive Care, Apr. 2-5, Carillon Hotel, Hollywood, Florida*

"Advances in Endocrinology," Apr. 8-9, Skycenter Inn, Jacksonville International Airport. For information: JHEP, 655 West 8th St., Jacksonville 32209

Office Management of the Infertile Couple, Apr. 9, Miami Beach. For information: Am. Fertility Soc., 1608 13th Ave. S., Birmingham, Al 35205

Fifth Annual Cardiovascular Consecutive Case Study Conference, Apr. 9-11, Sawgrass, Ponte Vedra (Jacksonville Beach). For information: Florida Heart Association, Box 10100, St. Petersburg 33733

Recent Developments in Gastrointestinal Surgery, Apr. 10-11, Pensacola Educational Program, Dept. of Surgery, 1200 W. Leonard St., Pensacola 32501

Ophthalmic Plastic & Corneal Surgery Symposium, Apr. 12-15, Doral Beach Hotel, Miami Beach*

Asymptomatic Coronary Artery Disease: Early Detection and Management, Apr. 22-23, Sheraton Towers, Orlando**

Cancer Conference: Cancer Detection in the Physician's Office, Apr. 23, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Symposium in Cardiovascular Nursing, Apr. 24-27, Sheraton Sand Key Hotel, Clearwater. For information: Am. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014

MAY

One Hundred Second Florida Medical Association Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

Sexual Dysfunction and Alternate Life Styles, May 7, Aboard the SS Monarch*

Neurology for Non-Neurologists III, May 13, University of South Florida, Tampa+

26th Annual Postgraduate Seminar: Medical-Surgical Dilemmas, May 13-15, Mt. Sinai Medical Center, Wolfson Auditorium, Miami Beach

Gastrointestinal Endoscopy, May 20-21, Americana Hotel, Miami Beach. For information: Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202

Scientific Bases of Clinical Practice, May 20-23, Innisbrook Resort & Golf Club, Tarpon Springs**

Cancer Conference: Serum Enzymes in Diagnosis of Malignancy, May 28, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Master Approach to Acute Cardiac Care, May 29-31, Contemporary Hotel, Walt Disney World*

Third Annual Family Practice Review, May 31-June 4, Hilton Inn, Gainesville**

Spring Symposia & Cruise in Obstetrics & Gynecology, May 31-June 6*

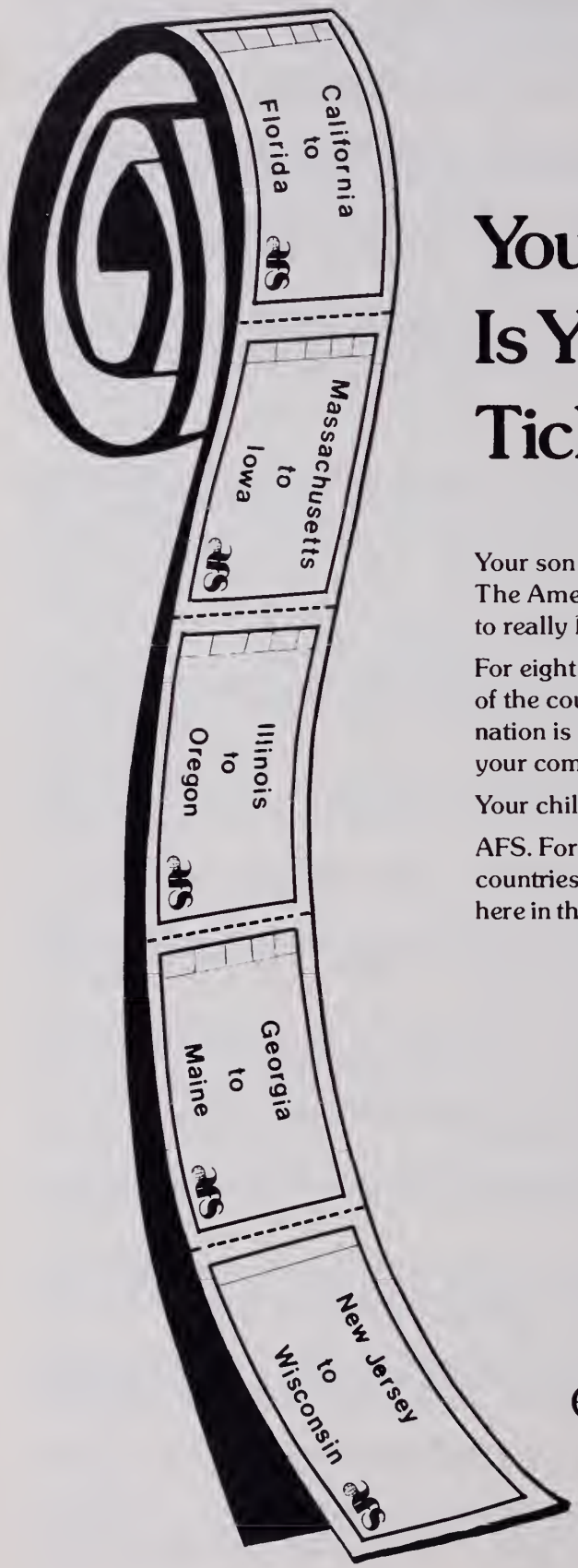
JUNE

Bascom Palmer Eye Institute Annual Residents Day, June 1976, Key Biscayne Hotel, Key Biscayne*

1976 Clinical Conference on Pre-Hospital Emergency Care, June 12-14, Orlando Hyatt House, Kissimmee. For information: ACEP, 1919 Beachway, Suite 5-C, Jacksonville 32207

Florida Suncoast Pediatric Conference, June 14-16, Sheraton Sand-Key, Clearwater*

Cancer Conference: Annual Report—Cancer Therapy End Results at St. Joseph's Hospital, Auditorium, June 25. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607



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SURGERY, GENERAL: Orlando, Orange County, east-central. American trained, board certified general surgeon sought for purchase of established practice in general surgery and Gyn. Immediate occupancy. Contact Alex P. Maybarduk, M.D., 710 East Colonial Drive, Orlando, Florida 32803. Phone (305) 293-9150.

ASSOCIATE WANTED: Established Obstetrician-Gynecologist in central Florida wants associate. Salary, leading to partnership. Reply to C-706, P.O. Box 2411, Jacksonville, Florida 32203.

OUR PRESENT DEPARTMENT OF PSYCHIATRY is a three man department. We wish to double the size of this over the next three to four years. All candidates must be Board eligible. General psychiatrists or someone with subspecialty interests would be acceptable. Our department is a member of a multi-specialty group located in Pensacola, Florida. Inquiries should be sent to W. M. C. Wilhoit, M.D., Chairman, Department of Psychiatry, The Medical Center Clinic, 1750 N. Palafax St., Pensacola, Florida 32501.

INTERNIST NEEDED: Board certified or board eligible with special interest in cardiology. New 180-bed rural community hospital in central Florida with 10-bed coronary care unit and no Internist. Will build, equip and lease new office OR salary and fringe benefits available as employee of existing PA composed of four family physicians practicing quality medicine. Starting salary range $50,000-$60,000. Write C-707, P.O. Box 2411, Jacksonville, Florida 32203.

TWO ANESTHESIOLOGISTS NEEDED: Growing multi-specialty group seeks affiliation with board certified or eligible anesthesiologists. Excellent opportunity to either join group or provide service to its staff and other physicians in the community. Beautiful northeast Florida coastal city with excellent hospitals and good school system. Write C-698, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPAEDIC SURGEON — FLORIDA PRACTICE. Board qualified or certified to join 2-man highly reputable orthopaedic practice in beautiful community. Send professional and personal critique to L. Cerino, M.D., 1800 North Federal Highway, Pompano Beach, Florida 33062. Phone: (305) 943-1922.

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WANTED: INTERNIST, FP'S, OB-GYN. Successful practice assured. 300 bed, modern hospital, University affiliated, new connecting office building—All urban advantages for your family. Staff retirements leave immediate patient load. Assistance includes six months free rent. Guaranteed minimum for right individual. Call collect or write to Dr. R. E. Wiltsie, East End Memorial Hospital, 7916 2nd Avenue South, Birmingham, Alabama 35206. Phone (205) 838-1611.

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POSITION WANTED: Family physician, Florida licensed, board eligible, seeks part time position within 10 mile radius of Deerfield Beach, Florida. Phone 428-0319.

POSITION DESIRED IN ELECTRODIAGNOSIS AND ELECTROMYOGRAPHY, considerable experience, interest in neurology. Group, hospital, or partnership considered; available July '76. Reply to C-711, P.O. Box 2411, Jacksonville, Florida 32203.

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CLINIC MANAGER / BUSINESS MANAGER desires change, multispecialty or medium size group. Experienced in accounting, billing, insurance, credit and collections, personnel and physician recruitment and purchasing. Group must be investment and P.A. oriented. Salary in mid to upper teens. Curriculum Vitae upon request. Write C-650, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST, 39, married, board certified in anatomic and clinical pathology, 6 years experience in large community hospital, seeks position of associate or director available July, 1975, national boards, Florida licensed. Write C-716, P.O. Box 2411, Jacksonville, Florida 32203.

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BOARD CERTIFIED INTERNIST, age 37, married; gastroenterology subspecialty including full endoscopy and biopsy procedures; seeks to relocate in Florida with group/partnership. Available 8/76. Write C-715, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN'S ASSISTANT is available immediately to work with internist or family practitioner in office or hospital setting. Has BA degree, graduate of two year approved AMA type A program. Prefer Miami area. CV upon request. Write C-717, P.O. Box 2411, Jacksonville, Florida 32203.

Practices Available

FOR SALE: Excellent quality practice in internal medicine, southwest coast of Florida, for price of office alone. Need about $15,000 down. Write C-712, P.O. Box 2411, Jacksonville, Florida 32203.

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FOR SALE: (1) Pelton Steam autoclave. (2) Burdick Microwave diathermy unit. (3) Burdick Muscle stimulator. (4) One articulated skeleton. (5) Picker x-ray unit, 300 ma, 125 pkv. 90/15 tilt table, fluoroscope, spot film device, floor to ceiling tube stand with electromagnetic locks, videx collimator, electronic bucky, 12/1 grid. Contact Alex Trombly, (813) 253-0481, 8:00 - 5:00.

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102nd ANNUAL MEETING
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Advertisers

Air Force Opportunities 114a

Atlantic Investment Advisers Service 117

Ayerst Laboratories Premarin 110-112

Burroughs Wellcome Co. Neosporin-G Cream 114a

Convention Press 118, 161

Geriatric Pharmaceutical Corp. Iso-Bid 134

Hill Crest Hospital Service 138

Lederle Laboratories Incremin 133

Eli Lilly & Co. Kefzol 122

Mallinckrodt, Inc. Lufyllin 114a

Mead Johnson Vasodilan 115

Medfield Center Service 117

Merck, Sharp & Dohme Indocin 162a

Pharmaceutical Manufacturers Assn. Institutional 144, 145

A. H. Robins Company Donnagel/Robitussin 154a, 155

Roche Laboratories Bactrim Third and Back Covers
Dalmane 146a

Roerig, A Division of Pfizer Pharmaceuticals Antiminth 118, 119
Antivert 162a

Smith, Kline & French Dyazide 146a

Westwood Pharmaceuticals, Inc. PreSUN 113

Willingway Hospital Service 163

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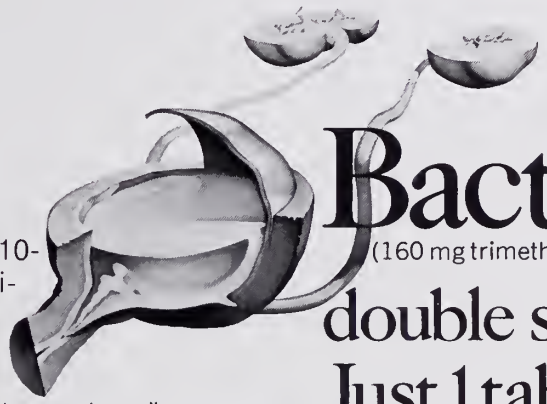
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1976 FMA Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions were mild (*e.g.*, nausea, rash), more serious reactions can occur with these drugs. See manufacturers' product information for complete listing.

Note: Bactrim single strength tablets were used in these clinical trials. However, studies have established the bioequivalency of Bactrim DS with the single strength tablets.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

double strength tablets Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

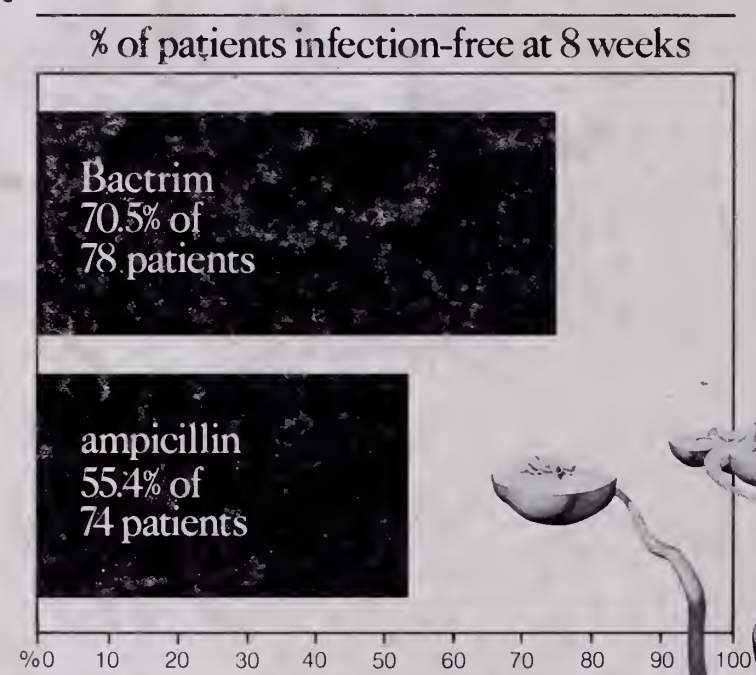
Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

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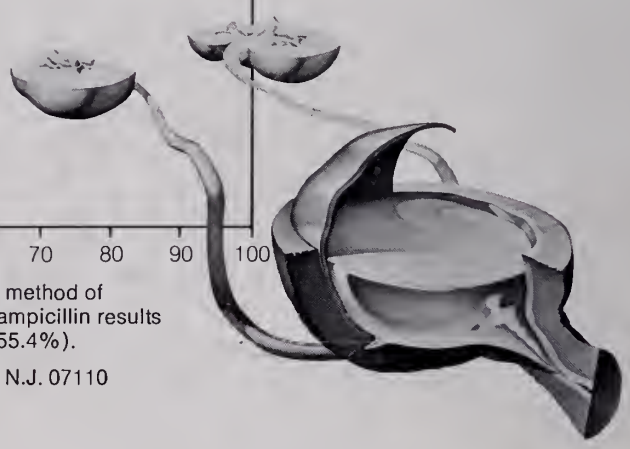
In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim™ was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110



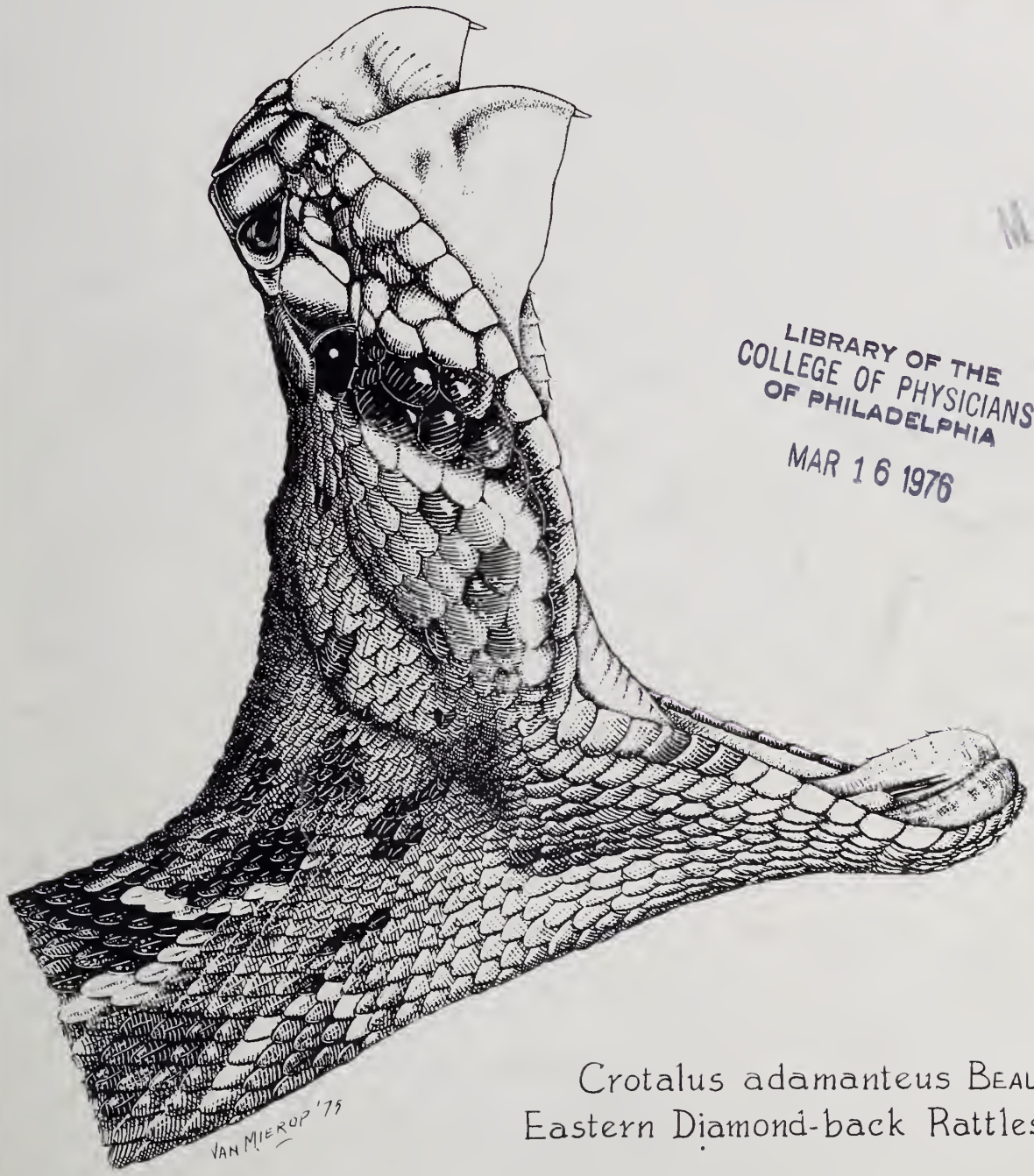
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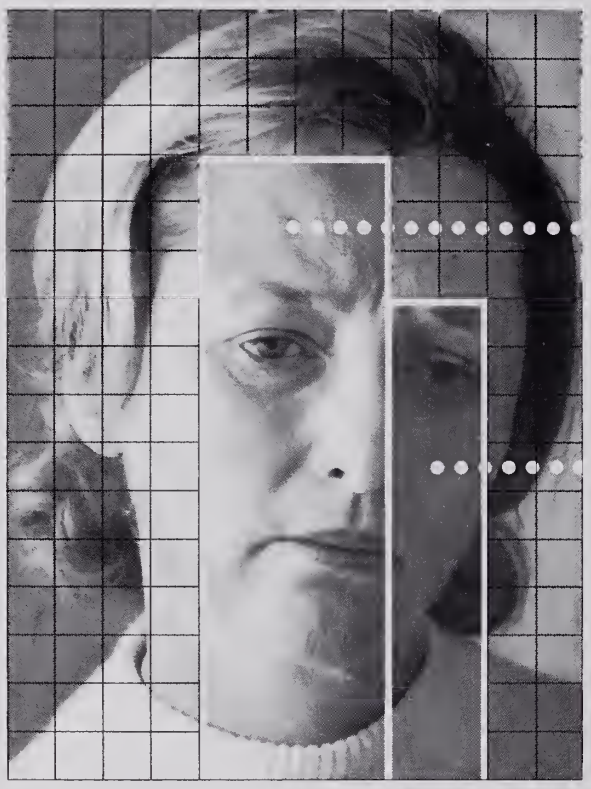
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SNAKEBITE SYMPOSIUM
L. H. S. Van Mierop, M.D.
Guest Editor

Proceedings FMA House of Delegates Interim Meeting, Jan. 29-Feb. 1, 1976, page 213

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Scientific Articles

Poisonous Snakebite—A Review
1. Snakes and Their Venom
L. H. S. Van Mierop, M.D. 191

Poisonous Snakebite—A Review
2. Symptomatology and Treatment
L. H. S. Van Mierop, M.D. 201

Organization

Proceedings of Florida Medical Association House of Delegates
Interim Meeting, Jan. 29-Feb. 1, 1976 213

Summary of FMA Meeting of Board of Governors, January 18, 1976 228

Scientific and Educational Exhibits, FMA Annual Meeting 229

More Speakers Added to Annual Meeting Program 230

Sections

President's Page
We Can Do The Job
VERNON B. ASTLER, M.D. 177

Books Received 235

Book Reviews 234

Dean's Page
Standards of Medical Education
CHANDLER A. STETSON, M.D. 184

Legislative News
On Chronic Diseases
John C. Kruse, M.D. 180

Letters to the Editor 238

Medical News Around the State 232

Others Are Saying
Determining the Right to Die—
A Physician's Responsibility
JOSEPH F. LUPO, M.D. 243

National Health Service
GORM P. HANSEN, D.D.S. 245

Very Real Peer Review
RALPH M. STEPHAN, M.D. 245

Woman's Auxiliary
Tenth Annual Benefit Art Show Application Blank .. 246

Information

Classified Advertising 247

FMA Officers and Council Chairmen 250

Information for Authors 237

Index to Advertisers 250

Meetings 187

March Cover— The cover depicts an Eastern Diamondback rattlesnake in the strike position. The fangs, sheathed in folds of the gums, have not as yet been fully erected. Primarily used as an efficient offensive weapon to kill food animals, the venom injecting apparatus is also employed quite effectively in defense. It was drawn especially for the Journal by Dr. L. H. S. Van Mierop to highlight his outstanding article entitled "Poisonous Snakebite: A Review." The two sections of this manuscript are subtitled: 1) "The Snakes and Their Venom," and 2) "Symptomatology and Treatment."



President's Page

We Can do the Job

On February 1, 1976, at a special meeting of the House of Delegates, an assessment of $100 per active member was voted by your County Medical Society representatives who sat as delegates. This money was specifically earmarked for legislative and public relations use and may not be withdrawn from escrow for any other purpose.

While assessments are seldom popular, I feel the support of the full membership is essential if free enterprise health delivery system in our profession, as we have known it, is to survive. Professionals in other healing arts are contributing up to $1000 per member and most trade unions assess $300-600 annually which explains the legislative clout they continually muster.

There is little doubt as to the almost direct correlation between money spent and results obtained in the legislative and public relations arenas. For example, the Florida Medical Association spent over $90,000 last year enjoining the Argonaut Insurance Company in a suit, and we prevailed. This victory saved over 13 million premium dollars which would have come from our members' pockets. Recently we spent approximately $20,000 in efforts before the Workmen's Compensation Commission to achieve the much needed updating of an antiquated fee schedule. The result was an approximate 32% across the board increase which will generate an additional $17 million in professional fees this year. Sizable amounts were spent to form our self-insurance trust last year, but the alternatives were to leave physicians with no professional liability coverage or force them into the Joint Underwriting Association at rates 2½ to 3 times the current rates offered by PIMCO. Once again, an immediate savings of over $20 million for the FMA members who chose to join our self-insurance trust.

During the past six months your FMA Board of Governors has hired Mr. John French as fulltime legislative attorney for our Capital office and Mrs. Nancy Moreau as legislative analyst. Previous to that, Mr. George Palmer was retained as our Tallahassee office manager and additional secretarial and clerical help was employed. A new centrally located downtown office property at street level was purchased adjacent to the Capitol. This will relieve our existing shortage of space and free us from our current fourth floor cubbyhole office.

An indepth public relations survey has just been completed by Civic Services, Inc. of St. Louis, Missouri. This survey has allowed us to sense the public mood in regard to physicians, their image, the liability crisis, and many other important matters. The monies assessed will allow us to pursue these public indicators and other much needed endeavors, and help to establish our patients as allies and restore our public image. Your FMA dollars have been spent wisely. The FMA is sensibly budgeted and financially sound, but we cannot go into reserves to meet the current crisis.

Your officers have devoted untold hours to these efforts without remuneration. The FMA executive staff has worked tirelessly (and often over-time) to our members' best interest. With your professional cooperation and your financial support we can do the job.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

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How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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LEGISLATIVE NEWS

On Chronic Diseases

The following is a letter concerning the malpractice crisis which recently came to my attention:

CENTURY-OLD COMPLAINT RE MALPRACTICE

To the Editor: The following are excerpts from a report on malpractice by Dr. Eugene F. Sanger.

Concerning the law: "As it is now, the unfortunate patient tries to retrieve his bad luck by levying upon the hard working surgeon, without risking or staking anything for the chance of testing what may prove to be no case at all . . . The suit depletes the surgeon's pocket and ruins his reputation. To pay is ruinous, to defend is ruinous, and to live in constant dread is ruinous . . . The plaintiff carries around a lame leg with the surgeon's money to support it, and the surgeon carries around a lame reputation with nothing to support it."

Concerning lawyers: "The lawyer has plenary power to arrest or bond the surgeon for appearance at court at his own expense, damage his reputation, wound his feelings and purse, for which the surgeon has no redress unless he takes it out of the lawyer's hide."

Concerning lawmakers: "We failed to get a bill through the last legislature to protect the science and art of surgery, mainly through the instrumentality of a low grade of lawyers, who kept out of sight their selfish and material interest in defeating it. My only reply is: Let these humane and philanthropic legislators contribute a moiety of their time and money to the suffering poor; let them run for the doctor at night, requite him for his thankless service, and, as an evidence of their sincerity and faith, become surety for the malpractice suits which they delight to encourage; let them work without retainers, relinquish their preferred claims on unsettled accounts and insolvent estates; let them step forward and cast their bread upon the waters, take the same risk that we do of prosecution for their mistakes, and the same chances of getting their pay, and their hypocritical cant will vanish into thin air."

J. E. McCallum, M.D.
University of Pittsburgh
School of Medicine
Pittsburgh, Pa.

This letter could have been written in almost any state within the last two years. It appeared in the New England Journal of Medicine, Vol. 294, No. 1, January 1, 1976 but its original publication was in the Boston Medical and Surgical Journal, **January 9, 1879**!!!!

The point we should realize is that the problems inherent in caring for the sick and injured and the hazards in delivering such care have been with us for a very long time and will continue to be with us. We must continue to seek solutions, be flexible and imaginative in our approach and aggressive and unapologetic in our presentations.

The House of Delegates, meeting in special session called by our President, Dr. Vernon Astler, adopted as FMA policy the conception that the whole problem of medical malpractice should be removed from the tort system to a broad based publicly financed system. This policy arose from ideas submitted by the Dade and Pinellas County Medical Societies, which were presented and discussed before the Reference Committee chaired by Dr. Sanford A. Mullen. Both societies recognized that their ideas were in the formative state, that many knotty details had to be worked out, and that the best course was to submit these ideas to the Board of Governors for study by them or a special committee of the Board. If possible, these ideas will be worked out in a form that can be submitted to the legislature this year.

The thrust of the legislative effort in the meantime will be measures aimed at reducing the cost of liability insurance which are being passed on to our patients, increasing the cost of their health care. See details of these proposals on page 220.

In addition, the Board of Governors, or whomever they designate, will investigate carefully the proposal by the Medical Liability Study Commission that would compensate, in a limited fashion, persons injured in the medical care systems without regard to fault, and will investigate the advisability of seeking legislation which would give "privileged communication" status to all medical records.

The Committee on State Legislation will vigorously pursue these broad policy guidelines as passed by the House of Delegates. What can you do to help? Speak out on the concepts to your patients, urging them to write letters to appropriate Senators and Representatives as indicated in last month's JFMA. Speak out before service clubs, church meetings, at social clubs, or to any other group that will listen to you. Write your State Senators and Representatives, call them up, speak to them personally. To all these groups, emphasize that these concepts will reduce the cost of insurance which will in turn reduce the cost of medical care. These are not pro-doctor proposals: These are pro-public proposals.

John C. Kruse, M.D., Chairman
FMA Committee on State Legislation
Jacksonville

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Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005



Dean's Page

Standards of Medical Education

Chandler A. Stetson, M.D.

This is a year in which the nation's medical schools can expect two Federal regulatory agencies to show increasing interest in the medical education system.

The first is the Equal Employment Opportunity Commission (EEOC), which has responsibility for insuring that hiring practices do not result in discrimination against women or racial minorities. Until now, the EEOC has largely confined its activities to involvement with industry; but it has now served notice that its mandate includes self-employed professionals as well. Our procedures relating to admissions, promotions, licensing and credentials will all be examined to determine whether any, or all of them, have the effect of discriminating against women or any minority group. If EEOC finds that any of the instruments presently used (such as medical college admission tests, National Board examinations, state licensing examinations, specialty board examinations, etc.) do have the effect of discrimination, then we must stop utilizing them. They could be continued only if we can prove that they are in fact necessary instruments — that is, that they accurately measure skills, knowledge or abilities that are in fact critically important performance indicators for medical practice.

The second agency with which we shall have to become concerned is the Federal Trade Commission. This Commission has recently evinced its interest in the professions of law and medicine, asserting that many of our traditional policies, practices and standards result in unfair and unnecessary exclusion from the professions, or otherwise operate in "restraint of trade." It is claimed that our admissions standards are too high, our performance indicators for graduation from medical school too high, our state licensing examination to be inappropriately difficult, and that in general it is far too difficult to gain access to the profession. Our ethical codes with respect to advertising, pricing, and other matters are all to be examined with respect as to whether or not they operate to restrain consumer access or limit consumer information.

Both of these agencies will be trying to attack some of our most cherished prerogatives and challenge the basis for the currently high standards of medical practice. It is unfortunate that these issues are being raised at a time when so many other factors and circumstances are tending to diminish both the quality of patient care and the standards of medical education.

In such an environment, a trying and unpleasant confrontation is bound to occur. We must certainly defend, with all the vigor we can muster, our right as professionals to set high standards for both entrance into our profession and practice within it. To conduct such a defense, without giving the appearance of being self-serving or elitist, will clearly demand our best effort. One hopes that all elements of the medical profession, including practitioners, medical educators and health administrators, will make common cause against this threat.

On the brighter side, medical educators throughout the nation were cheered by the Congressional override in January of President Ford's veto of the HEW appropriation bill HR 8069. Our sincere thanks go to both of Florida's senators and some representatives for their help in this matter. Our medical schools would have suffered another severe blow had the veto been sustained. In all likelihood we would have been faced with greatly reduced funding of many of our critical programs, at a time when neither state revenue nor private philanthropy could have been expected to come to our rescue.

Dr. Stetson, University of Florida College of Medicine, Gainesville 32601.

Dr. Stetson is Dean, University of Florida College of Medicine, Gainesville.

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Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

MARCH

Mediclinics, Mar. 1-12, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Walter J. Glenn, M.D., 1106 W E. Broward Blvd., Ft. Lauderdale 33301

Infant Nutrition, Mar. 4-5, University of South Florida, Tampa+

Selected Topics in Urology, Mar. 4-6, Hilton Hotel, Gainesville**

Fifth Annual Postgraduate Seminar in Dermatology, Mar. 5-7, Hyatt House, Miami Beach*

Courses of Instruction in Coronary Care for the Practicing Physician, Mar. 8-13, Jackson Memorial Hospital, Miami*

Second Annual Pediatric Surgical Postgraduate Course, Mar. 10-12, Deauville Hotel, Miami Beach. For information: William T. Brown, M.D., Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155.

"Cardiology Update—1976," Mar. 12-13, Amelia Island Inn, Amelia Island, Florida. For information: JHEP, 655 West 8th St., Jacksonville 32209.

Head and Neck Cancer Seminar, Mar. 13, Ramada Inn, Jacksonville Beach. For information: Nelson Goldman, M.D., 3599 University Boulevard S., Jacksonville 32218.

Longterm Psychiatric Care in Hospital Setting, Mar. 13-14, Anclote Manor, Tarpon Springs+

Symposium on Endocrinology, Mar. 15, Orange Memorial Hospital, Red Auditorium, Orlando**

Eighth Teaching Conference in Clinical Cardiology, Mar. 17-20, Sheraton Four Ambassadors Hotel, Miami*

Annual Suncoast Trauma Seminar, Mar. 18-20, Holiday Inn, Tampa+

Controversies in Cardiology, Mar. 18-20, Innisbrook, Tarpon Springs. For information: Sheldon Sbar, M.D., Tampa General Hospital, Tampa 33606

"Ninth Annual Instructional Course on Surgery of the Hand," Mar. 19-21, University Hospital, Jacksonville. For information: JHEP, 655 West 8th St., Jacksonville 32209

Advanced Life Support: The Fourth Annual Postgraduation Seminar in Emergency Medicine, Mar. 19-22, Americana Hotel, Miami Beach. For information: Registrar, 1976 PGS, 1919 Beachway Rd., Jacksonville 32207

6th Annual Special Procedures Seminar: How and Why We Do It (Radiology), Mar. 21-24, Hyatt House, Miami Beach*

Symposium on Hematology, Mar. 22, Orange Memorial Hospital, Red Auditorium, Orlando**

Fourteenth Clinical Radiology Seminar "How and Why we do Specific Radiology Procedures," Mar. 24-28, Hyatt House, Miami Beach*

Inflammatory Bowel Disease, Mar. 25, University of South Florida, Tampa+

Seventh Annual Topics in Internal Medicine, Mar. 25-27, Gainesville Hilton, Gainesville**

Topics in Adolescent Medicine for the Practicing Physician, Mar. 26, Aboard the SS Monarch*

Cancer Conference: Management of Bone Tumors, Mar. 26, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

Modern Look at Venereal Disease (Cruise), Mar. 26-29. For information: V. A. Marks, M.D., 784 U.S. #1, N. Palm Beach 33408

Diagnosis and Management of Airways Disease, Mar. 27-28, University of South Florida College of Medicine Medical Center, Tampa†

Post-Convention Seminar: Anatomic-Pathologic Correlations in Pulmonary & Gastrointestinal Diseases, Mar. 28-31, (Cruise)*

Diagnosis and Management of Obstructive Airways Disease, Mar. 29-30, University of South Florida, Tampa+

Symposium on Nephrology, Mar. 29, Orange Memorial Hospital, Red Auditorium, Orlando**

Symposium in Perinatology, Mar. 31-Apr. 3, Sonesta Beach Hotel, Key Biscayne*

Renal Disease & Hypertension, Mar. 31-Apr. 3, Americana Hotel, Miami Beach*

APRIL

Family Physicians Weekend, Apr. 2-4, Hilton Hotel, Gainesville. For information: Marshall D. Brainard, 4057 Carmichael Ave., Jacksonville 32207

"Highlights in Cancer—1976," Apr. 2, St. Vincent's Medical Center, Jacksonville. For information: Ashbel C. Williams, M.D., Cancer Education Dept., St. Vincent's Medical Center, Barrs & St. Johns Ave., Jacksonville 32204

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

▸ National meetings being held in Florida.

Spring Symposium in Intensive Care, Apr. 2-5, Carillon Hotel, Hollywood, Florida*

Anesthesia for Cesarean Section, Apr. 4, University of Florida, Gainesville**

Current Research in Obstetrical Anesthesia, Apr. 6, University of Florida, Gainesville**

Current Practice on Cardiopulmonary Resuscitation of the Asphyxiated Newborn, Apr. 7, University of Florida, Gainesville**

Antimicrobial and Infectious Disease Symposium, Apr. 10, Orange Memorial Hospital, Red Auditorium, Orlando**

"Advances in Endocrinology," Apr. 8-9, Skycenter Inn, Jacksonville International Airport. For information: JHEP, 655 West 8th St., Jacksonville 32209

▶**Office Management of the Infertile Couple,** Apr. 9, Miami Beach. For information: Am. Fertility Soc., 1608 13th Ave. S., Birmingham, Al 35205

Fifth Annual Cardiovascular Consecutive Case Study Conference, Apr. 9-11, Sawgrass, Ponte Vedra (Jacksonville Beach). For information: Florida Heart Association, Box 10100, St. Petersburg 33733

Recent Developments in Gastrointestinal Surgery, Apr. 10-11, Pensacola Educational Program, Dept. of Surgery, 1200 W. Leonard St., Pensacola 32501

Ophthalmic Plastic & Corneal Surgery Symposium, Apr. 12-15, Doral Beach Hotel, Miami Beach*

Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 19-24, Jackson Memorial Hospital, Miami*

Medical Symposium on Modern Management and Chemotherapy of Tuberculosis, Apr. 22, Hilton Inn West, Orlando. For information: Marianne B. McEuen, M.D., P.O. Box 210, Jacksonville 32201

Asymptomatic Coronary Artery Disease: Early Detection and Management, Apr. 22-23, Sheraton Towers, Orlando**

Cancer Conference: Cancer Detection in the Physician's Office, Apr. 23, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

▶**Symposium in Cardiovascular Nursing,** Apr. 24-27, Sheraton Sand Key Hotel, Clearwater. For information: Am. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014

MAY

Renal Disease, May 1-2, Holiday Inn, Ft. Pierce*

Neurological Disorders, May 1-2, Holiday Inn, Ft. Pierce*

One Hundred Second Florida Medical Association Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

Sexual Dysfunction and Alternate Life Styles, May 7, Aboard the SS Monarch*

Neurology for Non-Neurologists III, May 13, University of South Florida, Tampa+

26th Annual Postgraduate Seminar: Medical-Surgical Dilemmas, May 13-15, Mt. Sinai Medical Center, Wolfson Auditorium, Miami Beach

Cerebral Circulation and Metabolism, Intracranial Pressure and Anesthesia, May 17, University of Florida, Gainesville**

Anesthesia in the Patient on Chronic Drug Therapy, May 18, University of Florida, Gainesville**

Current Status of Halogenated Anesthetic Drugs, May 20, University of Florida, Gainesville**

▶**Gastrointestinal Endoscopy,** May 20-21, Americana Hotel, Miami Beach. For information: Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202

Scientific Bases of Clinical Practice, May 20-23, Innisbrook Resort & Golf Club, Tarpon Springs**

Cancer Conference: Serum Enzymes in Diagnosis of Malignancy, May 28, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

1976 Physicians' Seminar on Respiratory Disease, May 28-30, Turtle Inn, Atlantic Beach. For information: A. J. Azcuy, M.D., Box 8127, Jacksonville 32211

Colon Cancer and Lymphadenopathy, May 29, Flagler Hospital, St. Augustine. For information: S.A. Gunn, M.D., 159 Marine St., St. Augustine 32084

Master Approach to Acute Cardiac Care, May 29-31, Contemporary Hotel, Walt Disney World*

Third Annual Family Practice Review, May 31-June 4, Hilton Inn, Gainesville**

Spring Symposia & Cruise in Obstetrics & Gynecology, May 31-June 6*

JUNE

Bascom Palmer Eye Institute Annual Residents Day, June 1976, Key Biscayne Hotel, Key Biscayne*

1976 Clinical Conference on Pre-Hospital Emergency Care, June 12-14, Orlando Hyatt House, Kissimmee. For information: ACEP, 1919 Beachway, Suite 5-C, Jacksonville 32207

Florida Suncoast Pediatric Conference, June 14-16, Sheraton Sand-Key, Clearwater*

Florida Academy of Family Physicians Assembly, June 23-27, Marco Island. For information: Marshall D. Brainard, 4057 Carmichael Ave., Jacksonville 32207

Cancer Conference: Annual Report—Cancer Therapy End Results at St. Joseph's Hospital, Auditorium, June 25. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

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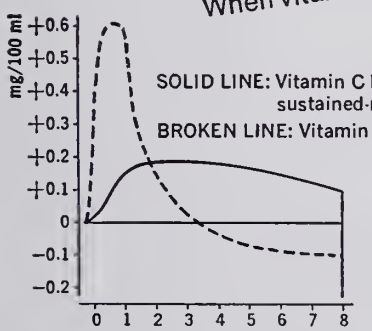


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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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THE JOURNAL
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Editor's Note.—Since the earliest recordings of the practice of medicine, physicians have distinguished themselves in other fields of endeavor. The Florida Medical Association has among its members many doctors who have inordinate talents and skills in such areas as art, music, and literature—in addition to being superior physicians. Such attributes immeasurably enrich our Association and contribute greatly to Florida's culture.

One of these gifted physicians is Lodewyk H. S. Van Mierop. Though certified by both the American Board of Pediatrics and the Sub-Board of Pediatric Cardiology, Dr. Van Mierop is additionally recognized as one of the nation's foremost cardiovascular embryologists, anatomists, and pathologists.

Since arriving in Florida in 1966, he has rekindled his longstanding interest in snakes—both as a scientist, as a consultant on snakebite injuries, and as their friend explaining the multiple ecological advantages of our snake population in Florida, along with destroying many of the myths and snake lore that have been transmitted from generation to generation.

His home is a virtual terrarium—housing a number of different species of snake. The Van Mierop family has the opportunity to observe first-hand many facets of snake life.

Recently, Dr. Van Mierop has written several scientific articles on the reproduction of the python and on the thermoregulation of the brooding female python.

Poisonous Snakebite: A Review

1. Snakes and Their Venom

L. H. S. Van Mierop, M.D.

Abstract: Medically important snakes of the U.S. are represented by two genera of the family Elapidae (Micrurus and Micruroides) and three genera of the subfamily Crotalinae (Crotalus, Agkistrodon and Sistrurus). Elapids have short, fixed fangs and a predominantly neurotoxic venom, Crotalids have long, movable fangs and in general their venom is hemotoxic, vasculotoxic and necrogenic. Because of the complexity and diversified action of snake venoms, their analysis is difficult. The study of the clinical aspects of snakebite cases is further complicated because of the release by the victim of substances which may produce more serious effects than the venom itself. Nevertheless, much has been learned concerning the composition and actions of the toxic, non-enzymatic venom polypeptides such as hemorrhagins, cardiotoxins and neurotoxins and the many mildly toxic or non-toxic venom enzymes, almost all hydrolases, e.g., procoagulant and bradykinin releasing esterases, proteases, phosphatases, etc. This increased knowledge of the action of snake venoms should result in a more rational approach to the management of cases of snakebite.

Morbidity and mortality of poisonous snakebite in the United States are very low. Parrish[1] estimated that approximately 6,680 persons were treated for poisonous snakebite in 1959. In that same year there were 14 fatalities, for a case fatality rate of only 0.21%. Moreover, about one-third to one-half of the individuals who have been bitten by poisonous snakes will have little or no evidence of envenomation.

Because cases of snakebite are uncommon, very few physicians in this country have the opportunity to carry out controlled studies on well-documented cases encountered in their own practice. This is one of the reasons why many aspects of the treatment of snakebite continue to be controversial, others are the absence of really valid statistics related to poisonous snakebite and the already mentioned fact that "a bite by a poisonous snake is not synonymous to snakebite poisoning."[2] Finally, until recently the actions of the many different kinds of snake venom, all complex animal poisons, were poorly understood.

While snakebite poisoning in terms of numbers of cases is not a major problem nationwide, it can

be one in certain localities where the larger species of venomous snakes are relatively common and, of course, to the bitten individuals faced with permanent disability, loss of a body part or even death, it represents a calamity.

In this paper I should like to review the genera of North American poisonous snakes, their venom delivery apparatus and the more important constituents of snake venoms and their mode of action. Exotic snakes will only be mentioned so far as this is of relevance in discussing various aspects of the general problem of envenomation due to snakebite.

The Snakes

Only about 10% of the species of snakes in the United States are venomous and of these the great majority belong to the subfamily Crotalinae or pit vipers. Pit vipers differ from the Old World "true" vipers (Viperinae) in that they possess a heat sensing organ located in a depression or "pit" on either side of the head between the nostril and the eye (Fig. 1). They are represented in the United States by three genera:

1. **Crotalus,** or large rattlesnakes, which have a well-developed rattle and of which there are more than 30 species and subspecies. There is at least one species of large rattlesnake in every mainland state of the Union except Maine, Michigan, Delaware, the District of Columbia and Alaska.[3] The Eastern and Western diamondback rattlesnakes **(C. adamateus** and **C. atrox)** are the largest (average 3½-5 feet) U.S. poisonous snakes and are counted among the most dangerous venomous snakes in the world.
2. **Sistrurus,** or so-called groundrattlers. This genus has two species: the more northern massasauga **(S. catenatus)** and the southern pigmy rattlesnake **(S. miliarius).**[4] Both species are comparatively small, particularly the latter (14-30 inches). The rattle is tiny and inconspicuous and the sound produced is barely audible.
3. **Agkistrodon,** or moccasins. There are two species in the U.S.: the large (2½-4 feet), heavy bodied and very dangerous cottonmouth or water moccasin **(A. piscivorus),** often confused with water snakes of similar size and bulk (Natrix spp.) living in the same habitat, and the much smaller (2-3 feet) copperhead or highland moccasin **(A. contortrix).** These two species of pit vipers do not have a rattle.

The family Elapidae, to which belong the cobras, the mambas, the kraits and, curiously, all of the poisonous snakes of Australia, is represented in the Americas by a number of genera and species of coral snake. Most are small (average 2-3 feet), slender snakes with smooth, shiny scales and are prettily colored with variously arranged transverse bands of red, black and yellow (or white). Only two genera, each with one species, occur in the U.S.: the Eastern

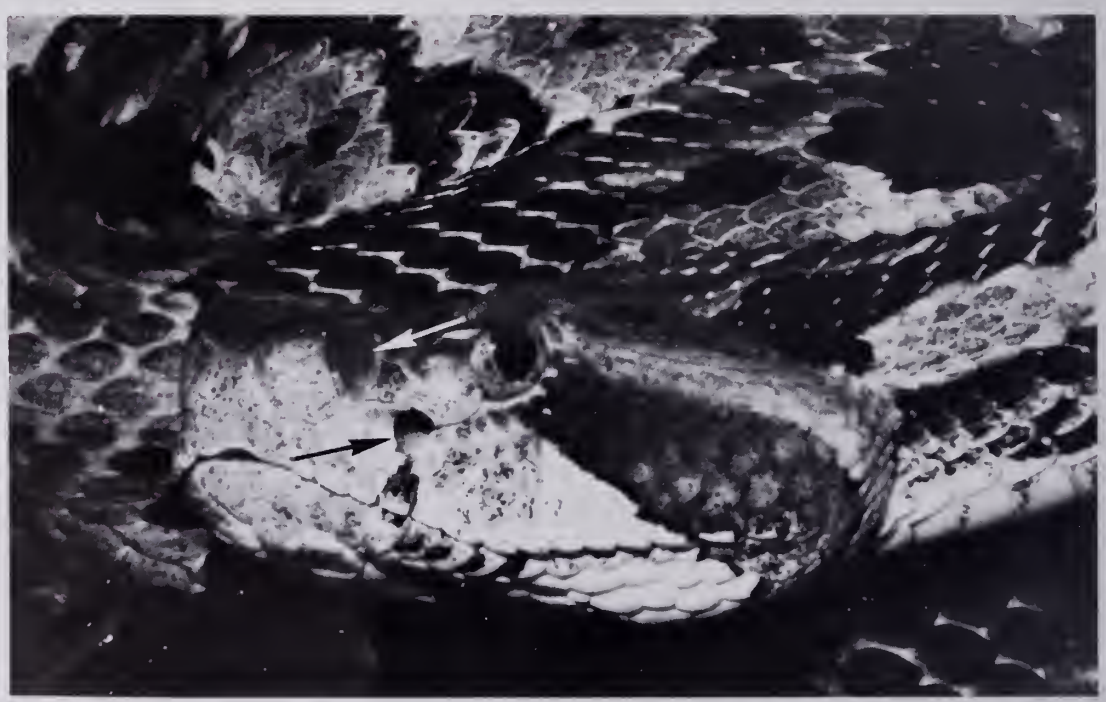


Fig. 1.—Head of Canebrake Rattlesnake. White arrow points to nostril, black arrow to loreal "pit."

coral snake **(Micrurus fulvius)**, and the Arizona coral snake **(Micruroides euryxanthes)**. Coral snakes are secretive, inoffensive and usually (but not always!) difficult to induce to bite. Their venom, however, is highly toxic and particularly the Eastern coral must be considered dangerous in spite of its small size. Fortunately, less than 2% of snakebites in this country are caused by coral snakes and many of these do not result in envenomation.

Venom Apparatus

Most snakes such as pythons and boas, and the vast majority of species of the very large and diverse family of colubrid, "common" snakes have a large number of simple, solid, sharply pointed and recurved teeth on the maxillae, the palatines, the pterygoids and the mandibulae. None of these teeth are particularly specialized and the snakes are said to be **aglyphous.** In a minority of colubrids the rear most maxillary teeth are slightly enlarged, grooved antero-laterally and associated with a venom gland, a condition referred to as rear fanged or **opisthoglyphous** (Fig. 2). None of the rear fanged snakes indigenous to the U.S. are dangerous to man.

All elapid and viperid snakes have a pair of well-developed, hollow poison fangs resembling curved hypodermic needles and located anteriorly on the upper jaws. In the living snake they are sheathed in a fold of the gum which is pushed back in the act of biting or stabbing (cover illustration). In elapid snakes, including the coral snake, the fangs are relatively short and fixed in position **(proteroglyphous)**. In vipers and pit vipers, on the other hand, the maxilla has become markedly foreshortened, carries only the fang and is freely hinged on the prefrontal bone. This allows the maxilla and the fang affixed to it to be rotated backwards when the animal's mouth is closed so that the fang lies along the roof of the mouth **(solenoglyphous)**. In the act of striking, however, when the mouth is wide open, the maxilla and fangs are rotated forward about 90° and become effective stabbing instruments. The folding mechanism allows for much greater relative fang length and a much more efficient injecting mechanism. As is true for all teeth in any snake, poison fangs are shed periodically (e.g., in the rattlesnake about every 6-8 weeks) and replaced by new ones. In fact, a replacement fang becomes functioning, taking up a position in the maxilla adjacent to its predecessor before the latter is discarded. A poisonous snake therefore will always have at least one, and for brief periods, two functioning fangs in each upper jaw. Behind the functional fangs there are always a number (5-7) of replacements at various stages of development. **A poisonous snake therefore cannot be rendered harmless for very long simply by removing its functional fangs.**

In non-poisonous snakes a mucus secreting gland, the superior labial gland, extends from the snout to just behind the angle of the mouth. The gland has many ducts which open into the groove between the lip and the lateral aspect of the upper jaw. Commonly, there is some differentiation of the gland into sections, and in many colubrid snakes its posterior portion is considerably larger and has its own capsule (Duvernoy's gland). Duvernoy's gland is believed to be analogous, but not homologous, to the mammalian parotid gland.[5] Its secretions are more or less toxic and in opisthoglyphous colubrids it is associated with the grooved fangs.

In elapid and viperid snakes the poison gland is quite separate from the superior labial gland and is located behind the eye (Fig. 3). It has a tough capsule to which is attached part of the adductor mandibulae superficialis muscle which helps to expel the venom. The venom gland consists of a posterior, main section and an anterior, mucus secreting, accessory gland. In elapids a common duct opens into the sheath of the fang, in vipers the accessory gland has its own duct.

The Venoms

Snake venoms are extremely potent and complex animal poisons, containing up to 10-15 enzymes, 3-12 non-enzymatic proteins and peptides, and other substances. Because of this complexity their study is difficult and sophisticated techniques are required to isolate and purify the various venom fractions. The study of the clinical aspects of snakebite poisoning is further complicated because of the release by the victim of substances such as histamine, bradykinin and adenosine which may produce more serious effects than the venom itself. Difficulties are also caused by the fact that venom composition varies not only among species, but also among individuals of the same species, depending upon age, geographic area, time of year, nutritional status and environmental conditions.

Nevertheless, much has become known in recent years concerning the composition and mode of action of snake venoms. This should result in a more rational approach to the management of clinical cases of snakebite. It also has provided us with new and important biological and therapeutic tools.

Until recently it was customary to classify snake venoms as being hemotoxic and vasculotoxic (causing hemorrhage, necrosis and shock, effects generally associated with viper and pit viper envenomation)

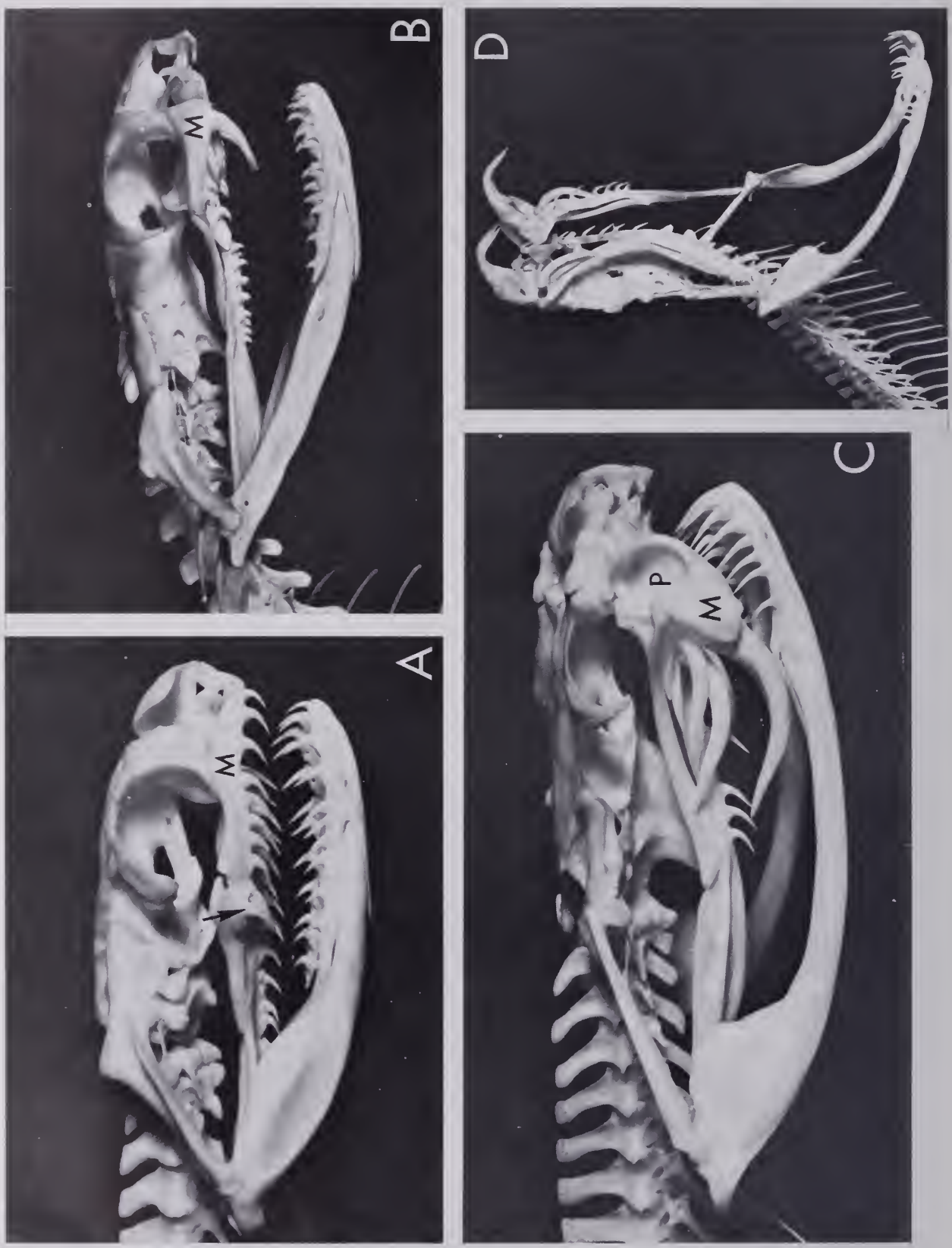


Fig. 2.—Head skeleton of (A) Mangrove snake (Boiga dendrophila: opisthoglyph); (B) King cobra (Ophiophagus hannah: proteroglyph); (C) Eastern diamondback rattlesnake (Crotalis adamanteus: solenoglyph); (D) Eastern diamondback rattlesnake, striking position. In this specimen, by coincidence, both fangs were being replaced simultaneously, resulting in a "double" fang on either side. M: Maxilla. P: Cavity in maxilla to accommodate the pit organ.

and neurotoxic and cardiotoxic (causing paralysis and cardiac dysfunction resulting in the cardiorespiratory type death associated with bites by elapid snakes). It is now well recognized, however, that most snake venoms exert simultaneous toxic effects, directly or indirectly, on the blood, cardiovascular, respiratory and nervous systems. Moreover, some pit vipers and vipers produce a strongly neurotoxic venom as, for example, the South American rattlesnake **(Crotalus durissus)**, the Mojave rattlesnake **(C. scutulatus)** and the Palestine viper **(Vipera xanthina palestinae)**, while the bite by some elapids, e.g., the Indian cobra **(Naja naja naja)**, may cause necrosis and hemorrhagic phenomena. As Russell[6] has pointed out, oversimplified classifications of the physiopharmacological properties of snake venom may lead to serious errors in clinical judgement.

A large body of literature dealing with snake venoms has been published and a good many publications are added every year. In what follows I have attempted to summarize present knowledge of those aspects of the biochemistry and pharmacology of snake venoms which I believe to be of interest and importance to the clinician who may be called upon to deal with cases of snakebite. I have been immeasurably aided in this by the perusal of the excellent recent reviews by Jimenez-Porras,[7] Russell and Puffer,[6] Lee,[8] and Devi.[9]

Enzymes

Many enzymes are found in all snake venoms, e.g., phospholipase A, phosphatases (5′ nucleotidase, exonucleases, endonucleases, pyrophosphatases), exopeptidases, hyaluronidase, and L-amino acid oxidase. Proteases and amino acid ester hydrolases (endopeptidases) are enzymes typically found in crotalid and viperid venoms. Others, such as acetylcholinesterase, acid and alkaline phosphatase, occur only or chiefly in those of elapids. Contrary to what was believed previously, individual venom enzymes by themselves have a low toxicity or are nontoxic, and the lethality of venoms containing only enzymes appears to be due to the combined effects of these enzymes and substances released by the envenomated organism. The only venom constituents that are truly lethal by themselves are the non-enzymatic neurotoxins, cardiotoxins and hemorrhagins to be discussed below.

Phospholipase A, a phosphatide acyl hydrolase, is involved in diverse pharmacological and pathologi-

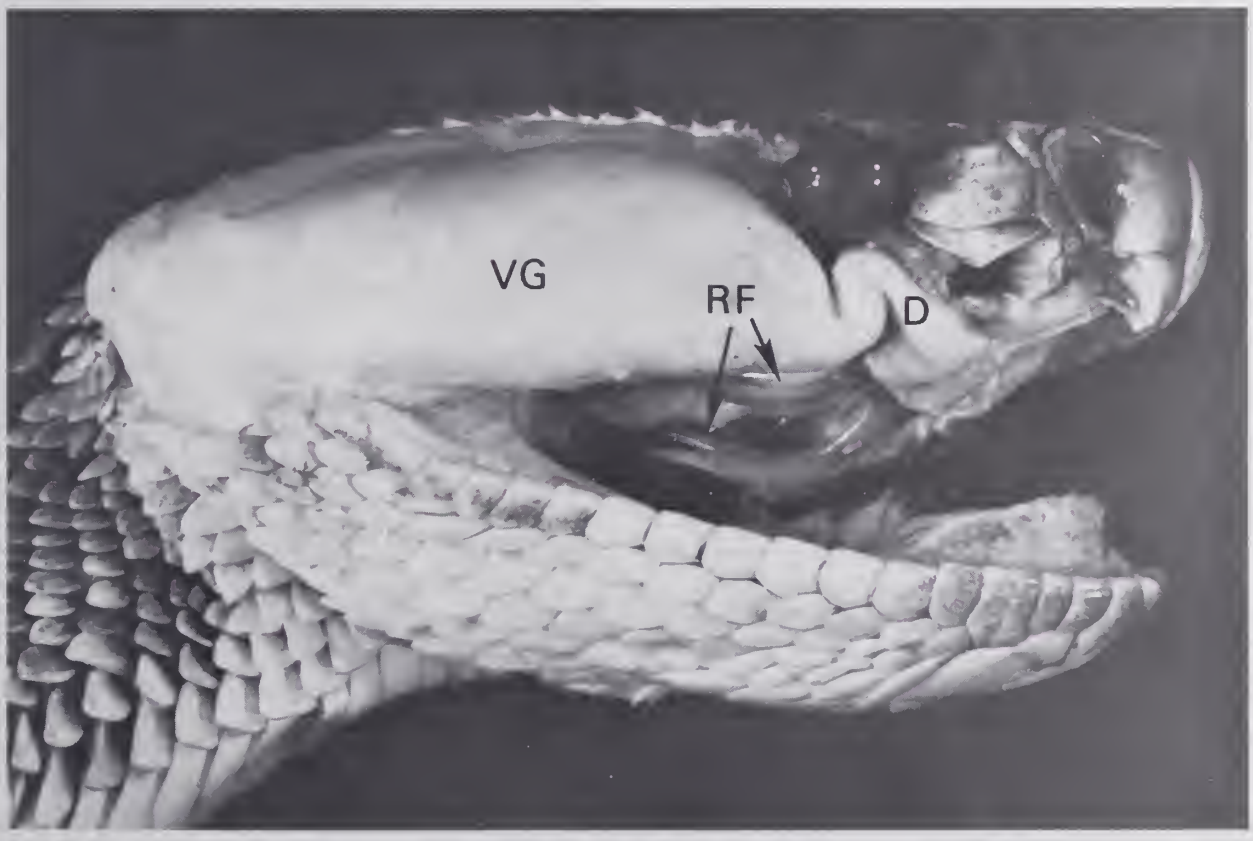


Fig. 3.—Dissection of the head of Eastern Diamondback Rattlesnake. VG.: Venom gland. D: Duct. RF.: Replacement fangs.

cal processes. It forms stable complexes with elapid and crotalid neurotoxins and has the ability to penetrate the intact cell and to destroy or alter certain phospholipids in nerve tissues resulting in effects which led to the claim that it was **the** neurotoxin in cobra venom. Phospholipase A participates through potentiation by direct lytic factor (cardiotoxin), in multiple other actions, e.g., lysis of erythrocytes and leukocytes, cardiotoxicity, cobra venom induced hemorrhage and probably also local myonecrosis.

Venom proteases are heat labile proteins that account for the anticoagulant, fibrinolytic and antithromboplastic effects of snake venoms and for the enhancement of plasminogen activation. They lack bradykinin releasing ability, although they can destroy this substance. They do not induce intravascular clotting and have no hemorrhagic properties, nor do they produce myonecrosis. In general, venoms with high proteolytic activity are poor coagulants (cottonmouth) and venoms with low proteolytic activity are markedly coagulant (Eastern diamondback rattlesnake). Similarly, venom of the copperhead is highly proteolytic but non-hemorrhagic, while the weakly proteolytic venom of the Eastern diamondback rattlesnake is strongly hemorrhagic. In the past the association of these various actions of crotalid and viperid venoms was based on the high protease content of such venoms and the lack of proteases in elapid venoms, the majority of which do not produce blood coagulation, disturbing, shocking, hemorrhagic and necrotic effects.

Proteases in general contribute little to the toxicity of even highly proteolytic venoms. Fibrinolysins for example, do not provoke the typical defibrination syndrome induced by the procoagulant esterases even though some venoms with powerful fibrinolytic activity in high concentration may prevent clotting of fibrinogen in vitro.

Hyaluronidase is present in nearly all snake venoms. It plays no role in venom induced hemorrhage but Russell[10] relates it to the edema and swelling at the site of the bite.

Acetylcholinesterase, present in high concentration in elapid venoms was also at one time believed to be **the** neurotoxin. It is absent from all non-elapid venoms, including those that are predominantly neurotoxic, and even from some highly neurotoxic elapid venoms, e.g., that of the Eastern coral snake.[11]

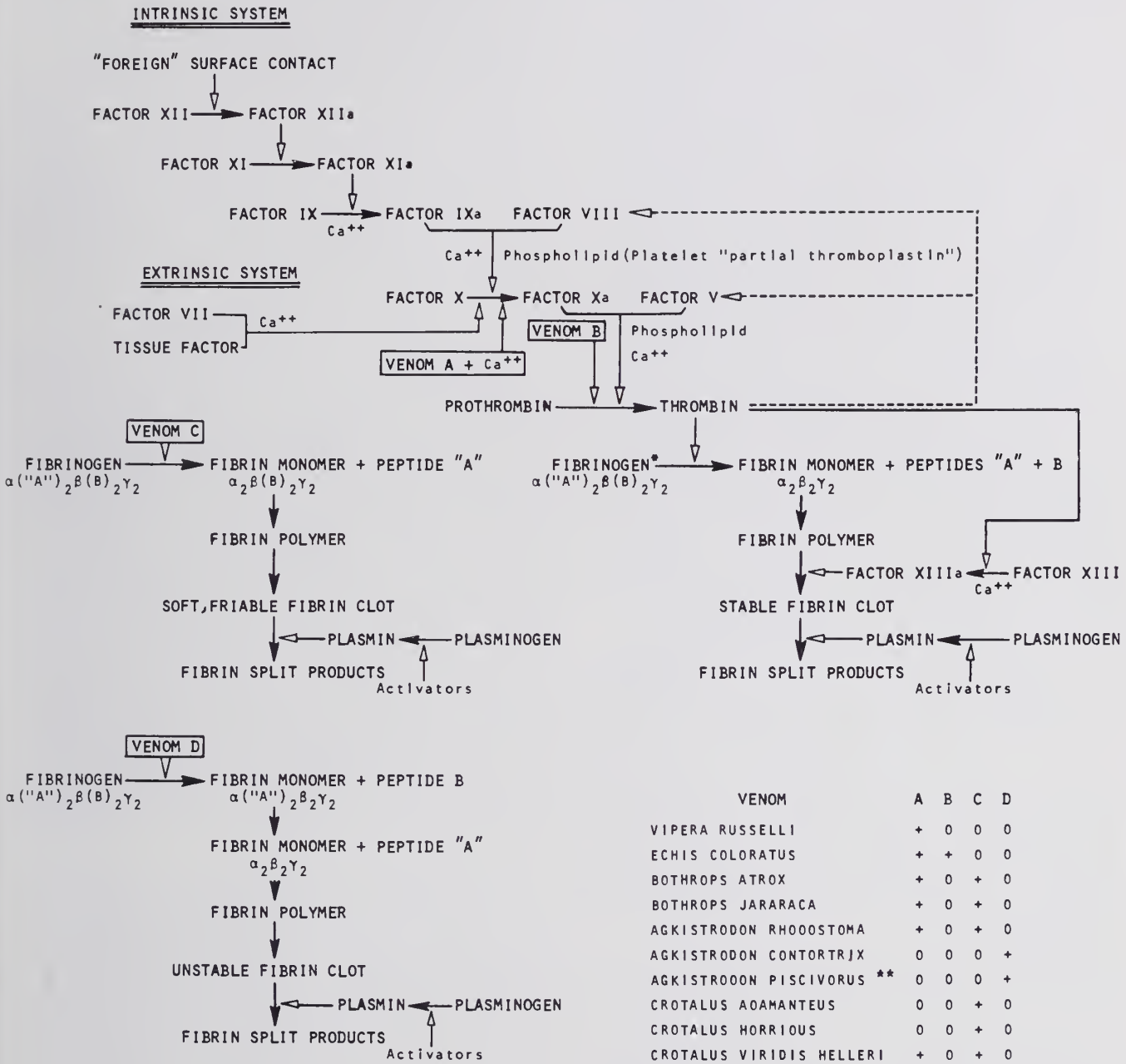
L-amino oxidase, a flavoprotein, is one of the very few non-hydrolytic enzymes in venoms and imparts the yellow color on the majority of them. It is absent from newborn and very young vipers and pit vipers, some elapid and all hydrophiid (seasnake) venoms. It catalyzes the reversible conversion of L alpha-amino acids into alpha-ketoacids. Because of its very low toxicity it is of little clinical importance, but it has found useful applications in research.

Snake venom phosphatases hydrolyze phosphate, ester or anhydride bonds in mono- or polynucleotides. A doubtful toxicity has been attributed to these nucleotides, in part because adenosine formed from nucleic acids can duplicate venom induced hypotension.

Venom amino acid (L-arginine) esterases are typically found in crotalid and viperid venoms, and are absent from those of elapids. They are of great interest because of their procoagulant and bradykinin releasing activities.

Bradykinin, a hypotensive, pain producing and smooth muscle stimulating nonapeptide, was discovered in the course of studies of the venom of the South American crotalid **Bothrops jararaca.**[12] It is released from serum bradykininogen by amino acid esterases which are similar to procoagulant esterases except for their specific enzymatic action on bradykininogen. Bradykinin is regarded as the main mediator in venom induced, abrupt (but transient) hypotension, but not in the persistent, lethal shock.

Procoagulant amino acid esterases cause intravascular clotting either by a thrombin-like action which converts fibrinogen to fibrin, or by activation of Factor X in the presence of Ca^{++}, followed by conversion of prothrombin into thrombin in the presence of Factor V, phospholipids and Ca^{++} (Fig. 4). The venom of saw scaled vipers (**Echis** spp.) not only has Factor X activating action, but in addition can convert prothrombin directly into thrombin.[13] Thrombin-like activity is almost restricted to crotalid venoms, and conversion of prothrombin into thrombin by activation of Factor X is typical of viperid venoms, e.g., that of Russell's viper, the prototype of this mechanism. Some crotalid venoms, e.g., that of the South American fer-de-lance **(Bothrops atrox)** and jararaca **(B. jararaca),** the Malayan pit viper **(Agkistrodon rhodostoma)**[13,14] and the Southern Pacific rattlesnake **(C. viridis helleri),**[15] exhibit both types of activity but the thrombin-like effect usually dominates. Thrombin-like procoagulants usually split off only peptide A from the fibrinogen molecule (Fig. 4)[16,17] unlike thrombin, which hydrolyses both peptides A and B in equimolar amounts, and do not activate Factor XIII (exception: **B. jararaca**) and a stable clot is not formed. Curiously, the venom of the cottonmouth **(A. piscivorus)** seems to split off only peptide B,[18] while that of the copperhead **(A. contortrix)** hydrolyses peptide B much faster than peptide A.[19] Hydrolysis of only



VENOM	A	B	C	D
VIPERA RUSSELLI	+	0	0	0
ECHIS COLORATUS	+	+	0	0
BOTHROPS ATROX	+	0	+	0
BOTHROPS JARARACA	+	0	+	0
AGKISTRODON RHOOOSTOMA	+	0	+	0
AGKISTRODON CONTORTRIX	0	0	0	+
AGKISTROOON PISCIVORUS **	0	0	0	+
CROTALUS AOAMANTEUS	0	0	+	0
CROTALUS HORRIOUS	0	0	+	0
CROTALUS VIRIDIS HELLERI	+	0	+	0

Fig. 4.—Diagrammatic portrayal of coagulation mechanism, showing reported sites of action of various venoms.
* Nomenclature recommended by the International Committee on Haemostasis and Thrombosis.
** Does not split off peptide "A". ("A"=A+AP+AY).

peptide B does not produce clotting,[15] by contrast the selective release of peptide A is sufficient to induce clotting, but the clot is soft and friable, particularly since Factor XIII is not activated. The microclots are readily lysed by the activation of the endogenous plasminogen-plasmin system, and possibly also by direct fibrinolytic action of the venom.

Clotting and fibrinolysis continue as long as venom is present and may result in a clinical picture closely resembling defibrination syndrome (disseminated intravascular clotting, D.I.C.) due to other causes, e.g., carcinoma, retention of a dead fetus and trauma,[20,21] etc., in which the defibrinating agent is presumed to be thrombin. Unlike thrombin, however, snake venom esterases do not always cause platelet aggregation, do not activate and destroy Factors V and VIII, and inhibition by heparin is at best partial and only at high doses. Thrombocytopenia after **C. adamanteus** envenomation, for example, is absent or mild, and other clotting factors are only mildly affected.[21,22] There is evidence that the venoms of the fer-de-lance and other crotalids contain a heparinase-like enzyme, which makes heparin ineffective in preventing the thrombin-like action of these venoms and explains, at least in part, the lack of inhibition of venom esterases by heparin.[23]

The defibrination produced by procoagulant esterases by itself does not usually lead to extensive hemorrhages and seems to be a rather benign state.[24] It does aggravate hemorrhages produced by the very potent hemorrhagins (see below) and trauma. In untreated snakebite victims defibrination with uncoagulable blood may persist for many days, yet there is no bleeding and the patients may be perfectly well otherwise. Defibrination is rapidly reversed with administration of antivenin, often within a few hours.

Russell's viper venom in high dilution has been used as a local hemostatic for the control of hemophilic bleeding ("Stypven").[25] A more recent therapeutic application of snake venom has been the seemingly paradoxical use of the purified coagulant fraction of **A. rhodostoma** venom ("Arvin") as an anticoagulant in the treatment of thrombotic disorders. "Arvin" produces complete defibrination and incoagulable blood within 3-4 hours. Fibrinogen is converted to soft and non-stabilized fibrin which is rapidly lysed in a benign way.[14] Larger than therapeutic doses do not prolong defibrination since the excess is excreted in the urine.

Bleeding disorders not due to arginine esterases are seen after bites by some elapid and viperid snakes (e.g., **Echis** spp.) and are believed to be due to direct, Ca^{++} independent conversion of prothrombin to thrombin, attributable to proteins which differ from esterases by their labile nature and weak or absent proteolytic and esterolytic activity, but are similar in their potent defibrinating properties.

Anticoagulant properties of the venom of some elapids and species of the viper genus **Bitis** is ascribed to interference with intrinsic and extrinsic thromboplastic systems[26,27] and platelet aggregation. Bleeding may also be related to interference with fibrin polymerization by fibrinogen degradation products resulting from a direct fibrinogenolytic effect of the venom.[26]

Non-Enzymatic Polypeptides

Hemorrhagins, typical components of crotalid and viperid venoms, are vasculotoxic agents whose main target organ appears to be the lung but which also cause rapid hemorrhagic edema at the site of the bite and bleeding elsewhere, leading to marked systemic hemorrhage and shock. Hemorrhagins (hemorrhagic principles) cause severe vasoconstriction, followed by vasodilatation of arterioles and subsequent hemorrhage in the capillary bed.[28] Endothelial cell junctions are affected and the basement membrane is disrupted, probably secondary to release of histamine and 5-hydroxytryptamine, allowing erythrocytes to leave the vessels. In addition there appears to be inhibition of platelet aggregation. Hemorrhagins do not have proteolytic or myonecrotic effects and there is no gross destruction of the vessel walls. This dissociation between proteolytic and hemorrhagic effects of venom was already alluded to above.

Cardiotoxin, a basic, heat stable, low molecular weight polypeptide, is extremely toxic for the mammalian heart. Its main action appears to be depolarization of all membranes affecting skeletal, cardiac and smooth muscle, nerves and the neuromuscular junction. Thus, it contributes to muscle paralysis and circulatory and respiratory failure. It also participates, through potentiation of phospholipase A in many other actions such as hemolysis and local myonecrosis. Cardiotoxin is abundant in cobra venom, and recently has been shown to be identical to direct lytic factor, cobramine B and cytotoxin.[29,30]

Neurotoxins are also strongly basic, heat stable polypeptides of small molecular size. They are typically found in elapid and hydrophiid venoms, and most are post-synaptic, non-depolarizing, neuromuscular blocking agents with curare-like action.[8] (Exception: β-bungarotorin and other, similar neurotoxins from the venom of **Bungarus multicinctus**

which act presynaptically.)[28] Their action differs from that of curare, however, in the slow development of the neuromuscular blockade, the imperfect antagonism by cholinesterase inhibitors and the absent or slow reversibility. It has been shown recently that reversibility of action depends on muscle susceptibility to the neurotoxin and on the length of the chain of the neurotoxin molecule.[31] The less susceptible the muscle and the shorter the molecular chain, the more reversible the block. Weis and McIsaac[32] recently showed that Eastern coral snake venom **(M. fulvius)** seems to act in a fashion analogous in some respects to the cardiotoxin of cobra venom, rather than on neuromuscular transmission through block of acetylcholine receptor sites, as do other elapid venoms. It appears to have a direct cardiotoxic effect and a depolarizing effect on skeletal muscles, and an effect on neuromuscular transmission could not be ruled out.

Neurotoxicity may also be a feature of crotalid and viperid venoms and a number of neurotoxins, different from those of elapids, have been isolated in more or less pure form, e.g., crotoxin, a curare-like, non-depolarizing, neuromuscular blocking agent; crotamine, a tetanic contraction inducing polypeptide; and viperatoxin, which interferes with peripheral nerve conduction. A neurotoxin similar in its effects to crotamine has been isolated from the venom of the Eastern diamondback rattlesnake.[33] The venom of only one North American crotalid, the Mojave rattlesnake **(C. scutulatus)** is predominantly neurotoxic without hemorrhagic or myonecrotic effects.

References

1. Parrish, H. M.: Incidence of treated snakebites in the United States. Public Health Rep. 81:269-276, 1966.
2. Reid, H. A.: The principles of snakebite treatment. Clin. Toxicol. 3:473-482, 1970.
3. Parrish, H. M.: Current concepts of snakebite treatment. G. P. 38:79-83, 1968.
4. Wright, A. H. and Wright, A. A.: Handbook of snakes of the United States and Canada. Comstock Publ. Assoc., Ithaca and London, 1957.
5. Kochva, E. and Gans, C.: Salivary glands of snakes. Clin. Toxicol. 3:363-387, 1970.
6. Russell, F. E. and Puffer, H. W.: Pharmacology of snake venoms. Clin. Toxicol. 3:433-444, 1970.
7. Jimenez-Porras, J. M.: Biochemistry of snake venoms. Clin. Toxicol. 3:389-431, 1970.
8. Lee, C. Y: Elapid neurotoxins and their mode of action. Clin. Toxicol. 3:457-472, 1970.
9. Devi, A.: The Chemistry, toxicity, biochemistry, and pharmacology of North American snake venoms. In: "Venomous Animals and Their Venoms." W. Bucherl and E. Buckley, eds., Vol. 11, Academic Press, New York and London, 1971, pp. 175-202.
10. Russell, F. E.: Clinical aspects of snake venom poisoning in North America. Toxicon 7:33-37, 1969.
11. Kumar, V., Rejent, T. A. and Elliott, W. B.: Anticholinesterase activity of elapid venoms. Toxicon 11:131-138, 1973.
12. Rocha e Silva, M., Beraldo, W. T. and Rosenfeld, G.: Bradykinin, a hypotensive and smooth muscle stimulating factor released from plasma globulin by snake venoms and by trypsin. Amer. J. Physiol. 156:261-273, 1949.
13. Nahas, L., Denson, K. W. E., and McFarlane, R. G.: A study of the coagulation action of eight snake venoms. Thromb. Diath. Haemorrh. 12:355-367, 1964.
14. Denson, K. W. E.: Coagulant and anticoagulant action of snake venoms. Toxicon 7:5-11, 1969.
15. Denson, K. W. E., Russell, F. E., Almagro, D. and Bishop, R. C.: Characterization of the coagulant activity of some snake venoms. Toxicon 10:557-562, 1972.
16. Ewart, M. R., Hatton, M. W. C., Basford, J. M. and Dodgson, K. S.: The proteolytic action of Arvin on human fibrinogen. Biochem. J. 118:603-609, 1970.
17. Holleman, W. H. and Coen, L. J.: Characterization of peptides released from human fibrinogen by Arvin. Biochem. Biophys. Acta 200:587-589, 1970.
18. Kornalik, F., Taborska, E. and Erbanova, Z.: The use of snake venoms in blood coagulation research and therapy. Toxicon 13:105, 1975 (Abstract).
19. Herzig, R. H., Ratnoff, O. D. and Shainoff, J. R.: Studies on a procoagulant fraction of Southern Cooperhead venom: The preferential release of fibrinopeptide B. J. Lab. Clin. Med. 76:451-465, 1970.
20. Reid, H. A., Chan, K. E., and Thean, P. C.: Prolonged coagulation defect (defibrination syndrome) in Malayan pit viper bite. Lancet 1:621-626, 1963.
21. Weiss, H. J., Allan, S., Davidson, E. and Kochwa, S.: Afibrinogenemia in man following the bite of a rattlesnake **(C. adamanteus).** Amer. J. Med. 47:625-634, 1969.
22. Markland. F. S. and Damus, P. S.: Purification and properties of a thrombin-like enzyme from the venom of **Crotalus adamanteus** (E. diamondback rattlesnake). J. Biol. Chem. 246:6460-6473, 1971.
23. Devi, A. and Copley, A. L.: Occurrence of heparinase-like enzyme in viperidae group of snakes. Toxicon 8:129, 1970 (Abstract).
24. Reid, H. A.: Defibrination by **Agkistrodon rhodostoma** venom. In: "Animal Toxins," F. E. Russell and P. R. Saunders, eds. Pergamon Press, New York, 1967, pp. 323-335.
25. McFarlane, R. G.: The coagulation action of Russell's viper venom; The use of antivenom in defining its reaction with a serum factor. Brit. J. Haemat. 7:496-511, 1961.
26. Forbes, C. D., Turpie, A. G. G., Ferguson, J. C., McNicol, G. P. and Douglas, A. S.: Effect of Gaboon viper **(Bitis gabonica)** venom on blood coagulation, platelets and the fibrinolytic enzyme systems. J. Clin. Path. 22:312-316, 1969.
27. McKay, N, Ferguson J C., and McNicol, G. P.: Effects of three cobra venoms on blood coagulation, platelet aggregation and fibrinolysis. J. Clin. Path. 22:304-311, 1969.
28. Ohsaka, A.: An approach to the physiological mechanisms involved in hemorrhage: Snake venom hemorrhagic principles as a useful analytical tool. Toxicon 13:112, 1975 (Abstract).
29. Slotta, K. H. and Vick, J. A.: Identification of the direct lytic factor from cobra venom as cardiotoxin. Toxicon 6:167-173, 1969.
30. Lee, C. Y., Linn, J. S. and Wei, J. W.: Identification of cardiotoxin with cobramine B, direct lytic factor and cobra venom cytoxin. Toxicon 8:140, 1970 (Abstract).
31. Lee, C. Y., and Chen, Y. M.: Species differences in reversibility of neuromuscular blockade by elapid and sea snake neurotoxins. Toxicon 13:106, 1975 (Abstract).
32. Weis, R. and McIsaac, R. J.: Cardiovascular and muscular effects of venom from coral snake, **Micrurus fulvius.** Toxicon 9:219-228. 1971.
33. Bonilla, C. A., Fiero, F. and Frank, L. P.: Isolation of a basic protein neurotoxin from **Crotalus adamanteus** venom. I. Purification and biological properties. Toxicon 8:123, 1970.

First Aid

1. Immobilize bitten limb if at all possible and keep below heart level but not dependent. Reassure the victim.
2. Apply mildly constricting tourniquet, obstructing only lymphatic and superficial venous blood flow, at least 10 cm. (4 inches) proximal to fang marks, or above first joint proximal to bite site. Release every 30 minutes for 60 to 90 seconds.
3. Wipe or wash off skin over fang marks.
4. Incision through fang marks and suction (I & S). Incisions need not be longer than 4 to 6 mm. (¼") and need only be carried through the skin. Oral suction should only be used if no other method is available. I&S are of greatest value if done immediately after the bite and should not be done if the interval has been longer than 30 minutes. Also unnecessary after coral snake bites. In exceptional cases of severe envenomation after bites by large pit vipers or exotic elapids (cobras, kraits) when no other treatment can be expected to be available for

many hours, a tight, completely occulding tourniquet may have to be used as a life saving measure with the full realization that the bitten limb may be lost.

Do not waste valuable time on first aid measures if a medical facility can be reached within a reasonably short time.

Do not give the patient alcohol.

Early Hospital Management

In severe cases several things may have to be done simultaneously: **Get adequate help.**

1. Identify the offending snake, if possible.
2. Reassure the victim: frightened individuals may calm down after a placebo injection, (tetanus toxoid or a skin test may be used for this). Analgesics may be given for pain but narcotics should be avoided after bites by coral snakes or other elapids.
3. If a tight tourniquet was put in place less than 1 hour prior to the patient's arrival, apply a loose one more proximally and remove the first one. A tourniquet may be removed once antivenin therapy has started. If a tourniquet has been left in place for several hours, sudden release may be dangerous. Antivenin therapy should be instituted as soon as possible and the tourniquet released gradually.
4. Immobilize bitten part if not already done.
5. Carry out skin or eye test for hypersensitivity to horse serum as described in the brochure enclosed with every package of antivenin.
6. Obtain history, including data on previous illnesses such as diabetes, heart disease, renal disease, hypertension and particularly allergies after exposure to horses and previous administration of horse serum. Carry out preliminary physical examination including at least a superficial evaluation of neurological status. Note and record vital signs, blood pressure and state of consciousness at more or less frequent intervals depending upon the gravity of the case.
7. Draw blood for CBC(blood sugar, BUN, electrolytes and do urinalysis. Additional blood should be obtained in victims of large pit viper bites for typing and cross-matching, transaminases, serum bilirubin, clotting time, prothrombin time, partial thromboplastin time, thrombin time, fibrinogen level and platelet count. Repeat these at more or less frequent intervals, again depending upon the severity of the bite. Obtain electrocardiogram in severe cases and in all patients over 40 years of age.
8. Start intravenous infusion. In severe cases it is advisable to establish two intravenous routes, one in each of two different limbs.
9. Give appropriate type antivenin, if indicated, early and in adequate amounts intravenously. Initial 0.2-0.5 ml. should be given slowly, even if sensitivity test was negative. Antivenin may be given either directly into the tubing by "push" or mixed with 500 ml. normal saline or similar physiologic intravenous fluid. Avoid overhydration, particularly in children. All patients bitten by coral snakes, even if asymptomatic, should receive an initial 2-4 vials of antivenin, if definite fang punctures are present and/or the snake "chewed" or "hung-on."

 If the skin or eye test was questionably or mildly positive or if the initial small amount of antivenin caused a reaction, proceed as indicated in the brochure accompanying antivenin. If patient is known to be sensitive to horse serum or if the skin or eye test was strongly positive, antivenin in general is contraindicated.
10. Respiratory distress should be treated appropriately with oxygen, endotracheal intubation or a tracheostomy and mechanical ventilation.
11. Tetanus toxoid and, if necessary, human tetanus immune globulin should be given. Gas gangrene antitoxin should not be used routinely.
12. The site of the bite should be clean and covered with a sterile dressing. Broad spectrum antibiotics are only necessary in the more severe cases and do not need to be used after bites by non-venomous snakes or in poisonous snakebite where there is no evidence of envenomation.
13. Use supportive measures such as blood transfusion, pressor agents, etc. as necessary and indicated.
14. If the offending snake was definitely a pit viper and no local swelling and erythema is present after 4 hours, no envenomation has occurred and the patient may be discharged. All other patients should be admitted for 24 hours for observation.

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Poisonous Snakebite: A Review
2. Symptomatology and Treatment

L. H. S. Van Mierop, M.D.

Abstract: Methods of treatment of poisonous snakebite continue to be controversial. Even the efficacy of such time-honored first aid measures as the use of a tourniquet, incision and suction has been questioned and denounced. Their use, however, is of definite benefit and justified after bites by North American pit vipers, if done within 30 minutes after the accident. Antivenin, the mainstay of treatment, should be given in adequate amounts, preferably intravenously, within 4 hours after the bite and over a period of one hour or less. Only then will it have beneficial effects not only on systemic envenomation but also on the local manifestations. Cryotherapy, early primary fasciotomies, steroids and antihistamines have no place in the early phases of treatment. Excisional therapy should only be considered (if at all) if it can be done within 30 minutes. All patients should receive tetanus prophylaxis, and broad spectrum antibiotics are recommended in all but the mildest cases.

Poisonous snakebite represents a medical emergency of the first order, calls for immediate and continued attention and the exercise of considerable judgement on the part of the physician. With good and speedy treatment the prognosis as to morbidity and mortality is excellent considering the seriousness of the event. Even with superior treatment, however, some degree of disability may result, particularly if the bitten part was the hand or foot, or if treatment was delayed due to circumstances beyond the control of the physician.

Most snakebite victims are males, many are young, the average age being about 25 years and a significant percentage are children. Most bites occur close to the home, during the summer months and in the afternoon. A significant number are inflicted in attempts at killing poisonous snakes or upon professional or amateur snake handlers.

About 98% of victims are bitten on the extremities below the elbow or knee. Pit viper bites usually result in one, two or occasionally more puncture wounds (fang marks), additional tooth marks are rarely seen. Coral snake fang marks are very small and hard to find, but may be multiple because the bite tends to be accompanied by chewing motions. Pit vipers, on the other hand, strike with great speed in a stabbing motion but do not hang on.

Medically important genera and species of North American snakes, their venom delivery apparatus and the more important constituents of snake venoms and their actions have been reviewed elsewhere.[1] Six species of venomous snakes, representing four of the five U.S. genera, occur in the State of Florida:

EASTERN DIAMONDBACK RATTLESNAKE (Crotalus adamanteus). Largest and most dangerous snake with long fangs and large quantity of quite toxic venom. Often quite irritable, striking with great force and speed, sometimes repeatedly and not always preceded by rattling. Can strike while in water.

Venom is strongly necrogenic but only mildly proteolytic. Bradykinin releasing activity present which contributes to the severe pain and may cause pronounced but transient hypotension. L-arginine esterase activity pronounced, producing defibrination (disseminated intravascular clotting) syndrome which may aggravate bleeding induced by hemorrhagins, or associated with trauma (incisions, needle punctures, etc.). Venom has a neurotoxic component which produces tingling sensations and fasciculations of skeletal muscle, especially of the face, but also of the extremities and elsewhere. The fasciculations are very common in human victims and when present after a bite by an unidentified snake should strongly suggest **C. adamanteus** as the offending reptile.

CANEBRAKE RATTLESNAKE (Crotalus horridus atricaudatus). Also a large snake and should be considered dangerous, although deaths are uncommon. Rather mild tempered, reluctant to strike and rattles loudly with little provocation for long periods.

Venom is similar in its effects to that of **C. adamanteus** but is less toxic. Still, the bite is a serious matter.

PIGMY RATTLESNAKE (Sistrurus miliarius barbouri). Small, but very common and irritable snake. Rattle very small producing barely audible, faintly buzzing sound, if any.

Venom is highly necrogenic, produces much pain and a remarkable degree of swelling. Hemorrhages may be present and the venom has some fibrinolytic activity. It is not neurotoxic and does not produce intravascular clotting or hemolysis. Lethality is low and no deaths have been reported in adults. A large specimen, however, could be dangerous to a small child.

COTTONMOUTH (Agkistrodon p. piscivorus). Large, often belligerent snake which stands its ground when come upon, often opening the mouth widely, showing its white interior. A typical water snake and common in Florida. Fangs are relatively short for a pit viper.

Venom is moderately toxic, highly proteolytic, and has both fibrinogenolytic and fibrinolytic activity. Also has bradykinin releasing and high phospholipase A activity. Only fibrinopeptide B is split off from fibrinogen by the venom, which is not sufficient to produce intravascular clotting and defibrination syndrome does not occur.

SOUTHERN COPPERHEAD (Agkistrodon c. contortrix). Small to moderate in size and generally not an aggressive snake but there are exceptions. Color pattern somewhat resembles that of a juvenile cottonmouth and the banded water snake with which it is often confused.

Venom is moderately proteolytic, resembling that of the cottonmouth in its characteristics but it is much less toxic. Few, if any, deaths are on record due to the bite of this snake.

EASTERN CORAL SNAKE (Micrurus f. fulvius). Small, slender, brightly colored snake with small head and very short fixed fangs. In Florida the Eastern coral snake differs from the similarly colored and patterned harmless scarlet king snake **(Lampropeltis d. doliata,** syn. **Lampropeltis triangulum elapsoides)** and scarlet snake **(Cemaphora coccinea)** in that the width and sequence of their colored transverse bands are different (in the coral snake the red and yellow bands touch, in the scarlet king snake they are separated by a black band) and the snout is black rather than red. A typical burrower, secretive and generally inoffensive. Bites are uncommon and in more than half of the cases apparently are not followed by evidence of envenomation. Still, the neurotoxic venom is extremely potent and the case fatality rate in symptomatic patients is high.

Note: The venom of juvenile (6-12 months old) pit vipers tends to be much more toxic than that of adults and may produce an unexpectedly severe clinical picture.[2,3]

Symptoms and Signs

Symptoms, signs and gravity of snakebite poisoning depend on age and size of the victim, the nature of the bite, species and size of the snake involved, its condition, the amount of venom injected, and the kind of first aid and subsequent hospital management provided.

The earliest, immediately occurring and most common symptom following any snakebite is **fear.**[4] Many people have an unreasoned fear of snakes in general, add to this the possible prospect of rapid and unpleasant death, and the intense fright is easily understood. Fear may cause symptoms such as weakness, dizziness, fainting, and cold and clammy skin. They should not be taken for systemic symptoms due to the actual bite since this might lead to unnecessary treatment. Emotionally induced symptoms will often respond to reassurance and a placebo injection for which the skin test or the tetanus toxoid injection may be used. These will have to be given in any case, whether or not significant envenomation is present.

PIT VIPER BITES. Pain and swelling are very characteristic early appearing symptoms of pit viper envenomation. Occasionally the pain is somewhat delayed but once it appears it may become very intense. Swelling may be progressive and may, in the more severe cases of envenomation, eventually involve an entire limb or even the ipsilateral trunk. **Discoloration** of the skin is common and in the more severe cases there may be **petechiae, ecchymoses,** and formation of **blebs** and **blisters.** Local **necrosis** to a varying degree is often seen. **Swelling** and **tenderness** of the **regional lymph nodes** is common, even if only a relatively minor degree of envenomation is present. **Subfascial tension** may become sufficiently great to obstruct venous and arterial blood flow leading to further necrosis or a marked functional impairment similar to Volkmann's contracture if not recognized and treated promptly. **Weakness, dizziness, cold** and **clammy skin, tachycardia, nausea, vomiting,** and **diarrhea,** as already stated, may be emotionally mediated and then appear within minutes after the bite. They may also reflect systemic envenomation, in which case they generally occur after a half hour or an hour or longer. **Hypotension** and a shock-like state may ensue and the heartbeat may become irregular.

Transient myosis is said to be a symptom of severe envenomation due to the bite of the Eastern diamondback rattlesnake.[5] Widespread damage to vessel walls in conjunction with venom induced intra-

vascular clotting resulting in the defibrination syndrome (consumptive coagulopathy), may lead to **hematemesis, hematuria, bloody diarrhea,** and more or less extensive **bleeding in internal organs.** In cases of severe envenomation hemolysis and hepatic and renal damage may occur leading to **hyperkalemia** and **acute renal failure. Numbness, tingling** about the face and lips and **fasciculations** of skeletal muscle, first in the affected limb and face and in severe cases becoming generalized, are an expression of the neurotoxic component of the venom of some pit vipers, e.g., the Eastern diamondback rattlesnake. **Convulsions** are said to be particularly common in children.

Wood, Hoback and Green[6] described three grades of severity for timber rattlesnake and copperhead bites. Parrish[7] added a grade 0 classification for the bite of a known venomous snake accompanied by no symptoms and McCollough and Gennaro[8] added a fourth (Table 1). This grading system may be helpful, particularly in patients who are seen by medical personnel for the first time several hours after having been bitten. Its criteria, however, should not be adhered to too rigidly, since this may lead to both undertreatment and overtreatment. Bites by pigmy rattlesnakes, for example, may cause edema out of proportion to the severity of the case. For that matter, much of the edema in cases of snakebite may be caused more by a tourniquet than by snake venom. On the other hand, victims of accidents caused by the large rattlesnakes seen very early may present with as yet few symptoms and signs. Since the aim of management of cases of snakebite should be **adequate** and **early** treatment with antivenin (if indicated) one should obviously not wait for 12 hours for grade 2 or 3 envenomation to develop.[9] Assessment of the (anticipated) severity of a case should ideally be based on the size and species of the offending snake, the location of the bite (which may give an idea as to the likelihood that the venom was deposited subcutaneously or intramuscularly), whether the bite was inflicted through clothing or footwear, and age, size and condition of the victim. If two fang marks are present, the distance between them may give an indication as to the size of the reptile. More venom tends to be injected if the biting snake meets some resistance, as in the case of a relatively thin layer of tissue overlying bone, e.g., the distal part of the extremities. If edema and erythema have not developed within 4 hours after the bite, the patient does not have pit viper envenomation.[9]

CORAL SNAKE BITES. The symptoms and signs of coral snakebite differ markedly from those seen after the bite of a pit viper and reflect the neurotoxic nature of the venom. There may be little or no pain or swelling and no local necrosis. Systemic symptoms may be markedly delayed, sometimes for many hours, but once they appear tend to progress rapid-

Table 1.—Grading of Envenomation

GRADE	DEGREE	CRITERIA	%	ANTIVENIN
		PIT VIPER BITES		
0	No envenomation	Fang marks and minimal pain only	27	None
1	Minimal	Fang marks, pain, 1-5" edema and erythema first 12 hours. No systemic involvement	37	None, in most cases
2	Moderate	Fang marks, pain, 6-12" edema and erythema first 12 hours and systemic symptoms may be present	22	Yes, 2-4 vials
3	Severe	Fang marks, pain, edema over 12" in 12 hours, systemic symptoms are present, including coagulation defects after pit viper bites	14	Yes, at least 5 vials
4	Very severe	Local reaction develops rapidly, edema may involve ipsilateral trunk. Ecchymoses, necrosis and formation of blebs and blisters	—	Yes, 10-20 vials or more
		CORAL SNAKE BITES		
0	No envenomation	Fang scratches or punctures, minimal local swelling. No systemic symptoms within 24 hours after bite	73	See text
1	Moderate	Fang punctures, minimal local swelling. Systemic symptoms, but no complete respiratory paralysis within first 36 hours	18	See text
2	Severe	As in Grade 1, but complete paralysis occurs within first 36 hours after the bite	9	See text

ly.[10] **Euphoria** and **drowsiness** may appear early, as do **nausea** and **vomiting. Marked salivation** is almost always present and is due not so much to increased production of saliva as to inability to swallow. **Paresthesias** in the bitten part, **headache** and a **bulbar type of paralysis** manifested by **ptosis, myosis, blurring of vision, difficulty breathing,** and **dysphonia** may develop later followed by **abnormal reflexes** and **general peripheral paralysis.** A grading system similar to that for pit viper bites was proposed by Parrish and Kahn.[10] Death occurs within 24 hours, if at all.[11]

Therapeutic Measures, Controversies

Almost every recommendation as to treatment of poisonous snakebite has been subject to controversy among clinicians and laboratory investigators. Measures considered to be beneficial and even life saving by one expert may be dismissed as useless or even harmful and contraindicated by others.

One reason for this confusing state of affairs is the limited number of individuals who have extensive experience in treatment of venomous snakebite. Others are the great differences in types of snakes involved and in socioeconomic conditions, e.g., availability and quality of medical facilities and transportation, between different countries or continents. Comparison of methods of treatment is hampered by the multiplicity of measures used in the management of any individual case, e.g., tourniquet, incision, suction, cooling, surgical interventions, drugs, hormones, antivenin, etc. Furthermore, a snakebite is an uncontrolled event: one does not or may not know how much venom was introduced, how deeply and where (subcutaneously, intramuscularly or occasionally intravenously), or what kind of venom it was. Finally, a bite by a venomous snake often generates so much fear or even hysteria in the victim that he may present with symptoms or signs closely simulating those of moderate or severe envenomation, even though, as is true in many cases, little or no venom was injected. Many such patients receive treatment (with excellent results) where none was necessary. Overtreatment of snakebite is a very real problem: of 335 patients with grade 0 envenomation reported upon by Parrish, et al,[9] 214, or almost two-thirds, received antivenin needlessly.

First Aid Measures. The traditional methods of first aid treatment have been and continue to be immobilization and the prompt application of a tourniquet to impede circulation and to retard absorption of the venom, followed by incision of the fang marks and suction. Most authors agree that immobilization of the bitten part, and if possible the patient, is extremely useful. The use of a tourniquet, incision and suction are much more controversial, particularly in the case of bites by elapids or Southeast Asian vipers and pit vipers. Many feel that an intermittently applied, lightly constricting ligature obstructing only lymphatic and superficial venous flow is efficient in reducing spread of the venom and makes incisions and suction (I&S) more effective. Others, however, disagree and consider I&S without value or even harmful.[4,12-14] Ya and Perry[15] found I&S useless when applied more than 30 minutes after injection of venom in the dog. Chapman[14] advocates the use of a tight and totally constructing tourniquet if it is applied less than one hour after the bite. The tourniquet should be an inch or more wide, should be released for brief periods every half hour, and in any case should not be left on for more than one and one half hours. Chapman condemns incisions for a number of reasons and feels that there is no place for this procedure as an early or late form of treatment except to drain abscesses. Reid[4] is skeptical of the efficacy of any of the usual first aid measures and simply advises to wipe off any venom from the skin surface, apply a firm but not tight tourniquet and get to a hospital as soon as possible. Russell,[16-18] however, considers a tourniquet obstructing lymphatic and superficial venous flow, and I&S of definite value in the case of North American pit viper bites, provided these measures are instituted within 30 minutes after the bite. A tight, totally obstructing tourniquet may be indicated if the bite was inflicted by a dangerous snake and it is anticipated that medical help will be hours away. Under these circumstances, the aim is to preserve life, realizing that the bitten part may be lost.[8]

Cryotherapy. Refrigeration in combination with a tight tourniquet as a form of treatment appears to be an extension of Crum's[19] suggestion that ethyl chloride spray might relieve symptoms of copperhead poisoning. This form of treatment, referred to as "cryotherapy" or "ligature and cryotherapy (L-C)" method, consists of packing the bitten limb in fresh water ice for hours, days or even weeks while sustaining body warmth. It was believed that cooling would inactivate the enzymes of the venom and slow absorption of the venom enough so that the body could keep up with its detoxification.[20,21] It was popularized by Stahnke[22,23] some twenty years ago and has been advocated by others.[24-26] This led to extensive use of cryotherapy even though no controlled studies or statistically significant data were ever offered to support the theoretical beneficial effects of cooling. It soon became apparent that this form

of treatment often caused more damage to the affected limb than the venom itself, in part because of frostbite, in part as a result of vascular damage and ischemia and in part due to renewed activity of the venom after rewarming of the limb.[20,21,27,28] McCollough and Gennaro,[8] in an analysis of 36 cases of amputation after snakebite, found that cryotherapy had been used in 27, or 75%. In 23 of these cases refrigeration had been used from 12 hours to 3 weeks. These authors, in agreement with most others, concluded that cryotherapy has no place in the treatment of snakebite unless amputation is already anticipated. There were no deaths or amputations among 208 cases of poisonous snakebite reported in Florida in 1969, and in none of these cases was cryotherapy used.

Surgical Measures. Ideally, bites by venomous snakes should (and usually do) remain a medical problem. Surgical intervention may be necessary in very severe, rapidly progressing cases or in those in which antivenin treatment has been delayed or has been inadequate. More or less wide excision of the bite site would seem to have merit on theoretical grounds.[32-34] Published reports[35,36] advocating this form of therapy, however, have not convinced me that in general it has any advantages over early and adequate treatment with antivenin. It would have to be done preferably within minutes and certainly within an hour after the bite and under ideal circumstances. There is no evidence that multiple incisions and suction following the line of proximally advancing edema removes significant amounts of venom.[28] If intense edema produces severe subfascial tension resulting in ischemia, multiple short skin incisions along Langer's lines, carried down to the deep fascia and combined with a longitudinal relaxing incision of the fascia may be necessary. The overlying skin and subcutaneous tissue will prevent massive herniation of muscle.[11] Long longitudinal incisions of skin and subcutaneous tissue, particularly when combined with longitudinal fasciotomy, with or without the use of steroids, as has been and still is being advocated,[37,38] produce unsightly scars, commonly result in disability and in my opinion have no place in the primary treatment of poisonous snakebite. Blebs and blisters should be treated in a manner similar to those seen after burns.

Antivenin. There is almost universal agreement that administration of antivenin is the mainstay of venomous snakebite treatment. Most experts agree that it should be given intravenously if possible. Absorption of subcutaneously or intramuscularly administered antivenin is slow, may be erratic, and, of course, none can be removed if serious hypersensitivity reactions occur. On the other hand, intravenous infusion, initially at a slow rate, may be stopped immediately if reactions occur. **It should be noted, however, that not all foreign manufactured antivenin against the bite of exotic venomous snakes can be given intravenously, and the brochure accompanying the package should always be consulted.** Injection of antivenin locally around the site of the bite is of doubtful value and in general is not recommended. Antivenin should never be injected under any circumstances into a finger or toe. Borden et. al.[39] demonstrated in experimental animals that envenomation could be treated by intra-arterial perfusion of the isolated bitten limb, and Snyder et al[35] employed a similar method clinically in combination with excisional therapy. This method of treatment, however, would require equipment and special skills not generally available in a doctor's office or average hospital emergency room.

Reid and others[1,10] feel that antivenin administered by whatever route does not prevent local tissue damage. Russell, however, has demonstrated that **early** antivenin therapy in **adequate amounts** definitely limits the local effects of the venom.[41]

Two types of antivenin, both of high quality and manufactured by the Wyeth Company, are available in the United States. Both are prepared from horse serum, one protects against the venoms of pit vipers, the other against the venom of both subspecies of **Micrurus** but not against that of the Arizona coral snake. As in all instances in which horse serum is to be used, the patient should be tested for hypersensitivity employing either a skin or eye test. Epinephrine, 1/1,000, drawn up in a syringe should be kept available for immediate use in the case of unfavorable reaction Particular caution should be used in testing individuals who give a history of allergy, especially to horses, or who have received horse serum previously. Positively reacting patients should be cautiously desensitized, if the use of serum therapy is considered to be imperative. Testing and desensitization procedures are described in detail in the brochure enclosed with each unit of antivenin. A negative skin or eye test is no guarantee that the patient will not react to subsequent antivenin infusion and an initial small amount should, therefore, be given slowly. If no reaction occurs after the first 0.2 to 0.5 ml., the remainder of the antivenin can be infused rapidly. **Antivenin, when indicated, should be given as soon as possible, in adequate amounts, and within a short period, not piecemeal, preferably within 4 hours and certainly no later than 24 hours after the bite.** Administration of very large amounts

of antivenin, e.g., 35 vials or more is rarely necessary, invariably causes serum sickness and in fact is dangerous. Serum sickness in any case occurs in a high percentage of patients, particularly if 5 or more vials have been given.

Pregnancy of the patient is no contraindication to serum therapy. Early and adequate treatment with antivenin may stop venom induced contractions in cases of severe envenomation and may prevent abortion.[12] Because of their smaller body size, children should receive more antivenin than adults, not only in a relative but also in an absolute sense. Antivenin should not be given routinely in all cases of pit viper bites; it may not even be necessary in cases of envenomation caused by the bite of copperheads or pigmy rattlesnakes, except possibly in the case of small children. Any antivenin given will probably sensitize the patient to horse serum and, therefore, may cause difficulty at a future time.

Other Therapeutic Measures. Individuals not previously immunized against tetanus should receive human tetanus immune globulin and tetanus toxoid; only toxoid is necessary in immunized patients. Gas gangrene antitoxin should not be given routinely. Antibiotics are usually recommended in all but the mildest of cases in which there are only superficial scratches, and in which washing with soap and water and application of an antiseptic is all that is necessary. Ledbetter and Kutscher[13] feel that attempted prophylaxis of all snakebite victims with broad spectrum or multiple antibiotics is really not feasible, since the bacterial flora present on fangs and in venom is extremely varied (yet includes very few pathogens) and no single antibiotic is effective against the majority of gram negative organisms. They quite correctly point out that the risk of infection should be minimized by neutralization of the venom with antivenin and by avoiding methods of treatment that impair circulation and enhance necrosis. Nevertheless, considering the nature of the wound and the circumstances under which initial incisional treatment, if any, was carried out, contamination with pathogens should be assumed and broad spectrum antibiotics such as ampicillin should be given.

As is true for all forms of D.I.C., treatment of the defibrination syndrome associated with bites inflicted by the large Crotalus species should be directed at eliminating the cause, i.e., the neutralization of the venom. Since venom amino acid esterases with thrombin-like action, unlike thrombin, are in general not inhibited by heparin, treatment with this drug cannot be expected to be effective, neither would the administration of platelet concentrates or blood factors, including fibrinogen, be very useful.

Loss of fluid and blood into edematous and ecchymotic tissues, or due to pooling, may be massive, necessitating whole blood transfusions. Administration of oxygen, pressor agents and steroids may be indicated in severe cases.

Endotracheal intubation, tracheostomy and assisted ventilation are necessary in patients with respiratory failure such as seen after bites by elapids including the Eastern coral snake.

Analgesics, including narcotics in some cases, and modest doses of sedatives and tranquilizers may be used in victims of pit viper bites. **Narcotics should not be given to patients bitten by coral snakes and other elapids.**

Hemodialysis may be necessary in patients with renal failure and hyperkalemia, peritoneal dialysis is not effective.

Physiotherapy should be begun as soon as practical, usually at about the fourth day after the bite.

ACTH and Corticosteroids, initially considered to have beneficial effects, were later found to be of little or no value[6,29] and might actually interfere with antivenin treatment.[28,30,31] Their use should be avoided during the acute phase of venomous snakebite treatment except possibly in patients with serious envenomation and stress induced shock. Steroids are of immense value in treating the more severe cases of serum sickness.

Antihistamines preferably should not be used concomitantly with the administration of antivenin but may be of value in the treatment of serum sickness.

COMPLICATIONS

Cases of **tetanus** have occasionally been reported after snakebite, but this complication can be avoided with the appropriate prophylactic measures. **Necrosis** can be extensive in untreated, mistreated or inadequately treated cases. While necrosis at the site of the bite cannot always be avoided, extensive **gangrene** and **amputation** should be uncommon with early and appropriate treatment. **Anaphylactic symptoms** usually begin within 30 minutes. Cutaneous and respiratory symptoms are most common, but laryngeal edema and hypotension may occur and may rapidly progress to a fatal outcome. Aqueous epinephrine 1/1,000, 0.3-0.5 ml. given intramuscularly, is the drug of choice in the treatment of anaphylaxis. In severe cases with marked hypotension, epinephrine can be diluted 1/10 in saline and slowly given intravenously. Tracheostomy may

First Aid

1. Immobilize bitten limb if at all possible and keep below heart level but not dependent. Reassure the victim.
2. Apply mildly constricting tourniquet, obstructing only lymphatic and superficial venous blood flow, at least 10 cm. (4 inches) proximal to fang marks, or above first joint proximal to bite site. Release every 30 minutes for 60 to 90 seconds.
3. Wipe or wash off skin over fang marks.
4. Incision through fang marks and suction (I&S). Incisions need not be longer than 4 to 6 mm. (¼") and need only be carried through the skin. Oral suction should only be used if no other method is available. I&S are of greatest value if done immediately after the bite and should not be done if the interval has been longer than 30 minutes. Also unnecessary after coral snake bites. In exceptional cases of severe envenomation after bites by large pit vipers or exotic elapids (cobras, kraits) when no other treatment can be expected to be available for many hours, a tight, completely occluding tourniquet may have to be used as a life saving measure with the full realization that the bitten limb may be lost.

 Do not waste valuable time on first aid measures if a medical facility can be reached within a reasonably short time.

 Do not give the patient alcohol.

Early Hospital Management

In severe cases several things may have to be done simultaneously: Get **adequate help.**

1. Identify the offending snake, if possible.
2. Reassure the victim: frightened individuals may calm down after a placebo injection (tetanus toxoid or a skin test may be used for this). Analgesics may be given for pain but narcotics should be avoided after bites by coral snakes or other elapids.
3. If a tight tourniquet was put in place less than 1 hour prior to the patient's arrival, apply a loose one more proximally and remove the first one. A tourniquet may be removed once antivenin therapy has started. If a tourniquet has been left in place for several hours, sudden release may be dangerous. Antivenin therapy should be instituted as soon as possible and the tourniquet released gradually.
4. Immobilize bitten part if not already done.
5. Carry out skin or eye test for hypersensitivity to horse serum as described in the brochure enclosed with every package of antivenin.
6. Obtain history, including data on previous illnesses such as diabetes, heart disease, renal disease, hypertension and particularly allergies after exposure to horses and previous administration of horse serum. Carry out preliminary physical examination including at least a superficial evaluation of neurological status. Note and record vital signs, blood pressure and state of consciousness at more or less frequent intervals depending upon the gravity of the case.
7. Draw blood for CBC, blood sugar, BUN, electrolytes and do urinalysis. Additional blood should be obtained in victims of large pit viper bites for typing and cross-matching, transaminases, serum bilirubin, clotting time, prothrombin time, partial thromboplastin time, thrombin time, fibrinogen level and platelet count. Repeat these at more or less frequent intervals, again depending upon the severity of the bite. Obtain electrocardiogram in severe cases and in all patients over 40 years of age.
8. Start intravenous infusion. In severe cases it is advisable to establish two intravenous routes, one in each of two different limbs.
9. Give appropriate type antivenin, if indicated, early and in adequate amounts intravenously. Initial 0.2-0.5 ml. should be given slowly, even if sensitivity test was negative. Antivenin may be given either directly into the tubing by "push" or mixed with 500 ml. normal saline or similar physiologic intravenous fluid. Avoid overhydration, particularly in children. All patients bitten by coral snakes, even if asymptomatic, should receive an initial 2-4 vials of antivenin, if definite fang punctures are present and/or the snake "chewed" or "hung-on."

 If the skin or eye test was questionably or mildly positive or if the initial small amount of antivenin caused a reaction, proceed as indicated in the brochure accompanying antivenin. If patient is known to be sensitive to horse serum or if the skin or eye test was strongly positive, antivenin in general is contraindicated.
10. Respiratory distress should be treated appropriately with oxygen, endotracheal intubation or a tracheostomy and mechanical ventilation.
11. Tetanus toxoid and, if necessary, human tetanus immune globulin should be given. Gas gangrene antitoxin should not be used routinely.
12. The site of the bite should be cleaned and covered with a sterile dressing. Broad spectrum antibiotics are only necessary in the more severe cases and do not need to be used after bites by non-venomous snakes or in poisonous snakebite where there is no evidence of envenomation.
13. Use supportive measures such as blood transfusion, pressor agents, etc., as necessary and indicated.
14. If the offending snake was definitely a pit viper and no local swelling and erythema is present after 4 hours, no envenomation has occurred and the patient may be discharged. All other patients should be admitted for 24 hours for observation.

SOURCES OF ANTIVENIN

Antivenin against the venom of pit vipers [Antivenin **(Crotalidae)** Polyvalent] should be available in every emergency room in the State.

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10. James Archer Smith Hospital, Homestead
11. St. Vincent's Hospital, Jacksonville
12. Lakeland General Hospital, Lakeland
13. Brevard Hospital, Melbourne
14. Jackson Memorial Hospital, Miami
15. Mt. Sinai Medical Center, Miami Beach
16. Naples Community Hospital, Naples
17. Orange Memorial Hospital, Orlando
18. Bay Memorial Hospital, Panama City
19. Baptist Memorial Hospital, Pensacola
20. Tampa General Hospital, Tampa
21. Division of Health, Jacksonville
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OUT OF STATE SOURCES

1. Communicable Disease Center, Atlanta, Georgia
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Antivenin against the venom of exotic snakes is kept at the Serpentarium in Miami, Fla. (Mr. William Haast) and at Ross Allen's Reptile Institute, Silver Springs, Fla., for at least all the snakes which they keep.

*(Information supplied by the Division of Health, Department of Health and Rehabilitative Services).

Fig. 1.- Venomous Snakes of Florida -and a Mimic.



A: Eastern diamondback rattlesnake.



B: Canebrake rattlesnake.



C: Pigmy rattlesnake.



D: Cottonmouth, juvenile.



E: Cottonmouth, adult.



F: Southern copperhead.



G: Eastern coral snake.



H: Scarlet king snake.

be necessary and bronchospasm should be treated aggressively with aminophylline 500 mg. intravenously slowly, realizing that this drug may increase hypotension. Persistent hypotension may respond to plasma or dextran infusion and vasopressor drugs, e.g., 4 ml. of 0.2% solution of Levophed® in 1,000 ml. of 5% dextrose in water, Ringer's solution or saline are necessary in some cases. Benadryl®, 50 mg., should be given early intramuscularly and every 6 hours. Prolonged anaphylactic symptoms may be treated with Solu-Cortef® (hydrocortisone succinate) 500 mg. IV every 6 hours. Steroids and antihistamines should never be used alone in treating anaphylaxis. **Serum sickness** usually manifests itself about a week or 10 days after antivenin therapy. The symptoms in most cases are malaise, fever, lymphadenopathy, arthralgia and urticaria. Encephalitis and peripheral neuritis, usually involving the upper brachial plexus, and pericarditis occur in some patients. In the treatment of serum sickness the drug of choice is Prednisone, the dose of which depends upon the seriousness of the individual case. In severe cases, 25 mg. four times a day may be necessary initially. This dose may be tapered rapidly when symptoms and signs decrease. Benadryl® 50 mg. every 6 hours may be given for the control of pruritis.

Individuals who have been bitten repeatedly by poisonous snakes or who have worked with snakes and who have inhaled dried venom dust may become sensitized to the venom itself, resulting in a hypersensitivity reaction when bitten again. In such cases the clinical picture may at least in part be due to a hypersensitivity reaction rather than to actual envenomation, in which case the patient should initially receive appropriate treatment for this, e.g., epinephrine. In addition, the usual treatment for envenomation should be instituted if indicated.

RECOMMENDATIONS FOR TREATMENT

In arriving at the following guidelines, consideration has been given to the above review of the literature on various aspects of poisonous snakebite, the recommendations of such experienced individuals as Russell, Parrish and McCollough and a review of the cases of poisonous snakebite seen in our institution over the past 5 years.

First Aid:

1. Immobilization of the bitten limb, if at all possible and practical, and reassurance of the victim **are the most important first aid measures.** Keep the limb below heart level, but not dependent.
2. Apply a mildly constricting tourniquet, obstructing only lymphatic and superficial venous blood flow, above the first joint proximal to the bite site or 4 inches proximal to the fang marks. A tourniquet should preferably not be left in place for more than 30 minutes or at most an hour without releasing it, intermittently, for 60 to 90 seconds.
3. Wipe or wash off the skin over the fang marks to remove any venom present.
4. Incision and suction (I&S). Incisions need not be longer than about ¼" and need only be carried through the skin. The aim of the incisions is to enlarge the fang puncture wounds to make suction more effective. Larger and deeper incisions simply cause more bleeding and may actually cause increased absorption of the venom. Cruciate incisions are not necessary and are not recommended. Oral suction should only be used if no other method is available. Suction need not be continued beyond 30 minutes after it was begun. I&S are of considerable value if done within 15 minutes after the bite and some venom can still be recovered up to 30 minutes. I&S are of no value after 30 minutes post-bite and should not be done after such a delay. There is no evidence that a tourniquet and I&S are of any value after the bite by elapid snakes and are unnecessary after coral snake bites. In exceptional cases of severe envenomation after bites by large pit vipers or exotic elapids when no other treatment can be expected to be available for many hours, a tight, completely occluding tourniquet may have to be used as a life saving measure with the full realization that the bitten limb probably will be lost.

Early Hospital Management. In severe cases several things may have to be done simultaneously: **Get adequate help.**

1. Ascertain, if possible, that the bite was indeed inflicted by a venomous snake and, if so, try to identify the offender.
2. Reassure the victim: severely frightened individuals calm down after a placebo injection for which tetanus toxoid or the skin test may be used. Analgesics may be given for pain but narcotics should be avoided after coral snake bites.
3. Check tourniquet if one has been used. If too tight and put in place less than one hour prior to the patient's arrival, apply a loose one more proximally and remove the first one. Tourniquet may be removed once antivenin therapy has started. If the tourniquet has been left in place

for several hours, sudden release may be dangerous. Antivenin therapy should be instituted as soon as possible and the tourniquet released gradually.

4. Immobilize bitten part if not already done.
5. Carry out skin or eye test for hypersensitivity to horse serum. Keep epinephrine 1/1,000 ready, drawn up in a syringe, for immediate use in case unfavorable reactions occur. These procedures are described in detail in the brochure enclosed with every package of antivenin.
6. Obtain history, including data on previous illnesses such as diabetes, heart disease, renal disease, hypertension and particularly allergies after exposure to horses and previous administration of horse serum. Carry out preliminary physical examination including at least a superficial evaluation of neurological status. Note and record temperature, pulse, respiration rate, blood pressure and state of consciousness. Repeat these at more or less frequent intervals depending upon the gravity of the case.
7. In all cases of snakebite, draw blood for CBC, blood sugar, BUN, electrolytes and do urinalysis. Additional blood should be obtained in victims of large pit viper bites for typing and cross-matching (these procedures may be difficult or impossible to do later due to the effects of the venom), transaminases, serum bilirubin, creatinine phosphokinase, clotting time, prothrombin time, partial thromboplastin time, thrombin time, fibrinogen level and platelet count. Repeat these at more or less frequent intervals, again depending upon the severity of the bite. Obtain electrocardiogram in severe cases, and in all patients over 40 years of age.
8. Start intravenous infusion, preferably with intravenous plastic tubing. In severe or potentially severe cases seen early it may be advisable to establish two intravenous routes, one in each of two different limbs. One of these is available at all times for antivenin infusion, the other for blood, plasma, etc. and medications.
9. Give appropriate type antivenin, if indicated, early and in adequate amounts intravenously. Initial 0.2-0.5 ml. should be given slowly even if skin or eye test was negative. If no hypersensitivity reaction follows the remaining amount may be given more rapidly, either directly into the tubing by "push," or mixed with 500 ml. normal saline, Ringer's lactate or 5% D/W. Do not give antivenin in one vial increments over many hours. If the (anticipated) severity of the case would warrant the administration of, for example, 8 vials, it is better to give the entire amount over a period of 30 to 60 minutes. Avoid overhydration, particularly in children. All patients bitten by coral snakes, even if asymptomatic, should receive an initial 2-4 vials of antivenin, if definite fang punctures are present and/or the snake "chewed" or "hung on."

 If the skin or eye test was questionably or mildly positive or if the initial small amount of antivenin caused a reaction, the patient should be desensitized as indicated in the brochure accompanying the antivenin. If the patient is known to be sensitive to horse serum or if the skin or eye test was strongly positive, antivenin in general is contraindicated. In such cases the risk of withholding antivenin as to possible loss of life should be weighed carefully against the risk of anaphylaxis. The options should be discussed in detail with the patient and/or his relatives and written consultations should be obtained if possible from other physicians. Difficulties may be avoided by the use of intravenous epinephrine,[5] diluted 1:10 with saline and given slowly as necessary. Mixing the antiserum with ephedrine prior to administration has also been recommended.[44]
10. Respiratory distress should be treated appropriately with oxygen, endotracheal intubation or a tracheostomy and mechanical ventilation.
11. Tetanus toxoid and, if necessary, human tetanus immune globulin should always be given. Gas gangrene antitoxin should not be used routinely. Broad spectrum antibiotics are only necessary in the more severe cases in which there is a definite local reaction to the venom. Antibiotics are not necessary after bites by nonvenomous snakes or in poisonous snakebite where there is no evidence of envenomation. In these cases the area of the bite should be washed and an antiseptic used.
12. If the offending snake was **definitely** a pit viper and no local swelling and erythema is present after 4 hours, no envenomation has occurred and patient may be discharged. All other patients should be admitted for 24 hours for observation.

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References

1. Van Mierop, L. H. S.: Poisonous snakebite: A review. I. The snakes and their venom. J. Florida Med. Assn. 63:191-200 (Mar.) 1976.
2. Minton, S. A., Jr.: Observations on toxicity and antigenic makeup of venoms from juvenile snakes. In: "Animal Toxins." F. E. Russell and P. R. Saunders, eds., Oxford and New York, Pergamon Press, 1967, pp. 211-222.
3. Fiero, M. K., Seifert, M. W., Weaver, T. J. and Bonilla, C. A.: Comparative study of juvenile and adult prairie rattlesnake (Crotalus viridis viridis) venoms. Toxicon 10:81-82, 1972.
4. Reid, H. A.: The principles of snakebite treatment. Clin. Toxicol. 3:473-482, 1970.
5. Watt, C. J., Jr. and Gennaro, J. F., Jr.: Pit viper bites in South Georgia and North Florida. Trans. Southern Surg. Assn. 77:378-386, 1965.
6. Wood, J. T., Hoback, W. W. and Green, T. W.: Treatment of snake venom poisoning with ACTH and cortisone. Virginia Med. Monthly 82:130-135, 1955.
7. Parrish, H. M.: Poisonous snakebites resulting in lack of venom poisoning. Virginia Med. Monthly 86:396-401, 1959.
8. McCollough, N. C. and Gennaro, J. F., Jr.: Evaluation of venomous snakebite in the Southern United States from parallel clinical and laboratory investigation. Development of treatment. J. Florida Med. Assn. 49:959-967, 1963.
9. Parrish, H. M., Goldner, J. G. and Silberg, S. L.: Poisonous snakebites causing no venomation. Postgrad. Med. 39:265-269, 1966.
10. Parrish, H. M. and Kahn, M. S.: Bites by coral snakes: Report of 11 representative cases. Amer. J. Med. Sci. 253:561-568, 1967.
11. McCollough, N. C. and Gennaro, J. F., Jr.: Treatment of venomous snakebite in the United States. Clin. Toxicol. 3:483-500, 1970.
12. Efrati, P. and Reif, L.: Clinical and pathological observations on sixty-five cases of viper bite in Israel. Amer. J. Trop. Med. Hyg. 2:1085-1108, 1953.
13. Kathan, R. G., Huber, G. S. and Leopold, R. S.: Evaluation of the tourniquet and incision and suction treatment of snakebite. Special report NM-005-052.08, Navy Medical Field Res. Lab., 1956.
14. Chapman, D. S.: The symptomatology and treatment of the bite of venomous snakes of Central and Southern Africa. In: "Venomous Animals and Their Venoms." W. Bucherl, E. E. Buckley and V. Deulofeu, eds., Vol. 1, Academic Press, New York, 1968, pp. 463-527.
15. Ya, P. M. and Perry, J. F.: Experimental evaluation of methods for the early treatment of snakebites. Surgery 47:975-981, 1960.
16. Russell, F. E.: Clinical aspects of snake venom poisoning in North America. Toxicon 7:33-37, 1969.
17. Russell, F. E. and Emery, J. A.: Incision and suction following the injection of rattlesnake venom. Amer. J. Med. Sci. 241:160-166, 1961.
18. Russell, F. E., Quilligan, J. J., Jr. and Rao, S. J.: Snakebite. JAMA 195:596-597, 1966.
19. Crum, C. W. R.: Treatment of the bites of copperhead snakes by local freezing combined with the frequent application of a potassium permanganate solution. JAMA 46:1433-1434, 1906.
20. Merriam, T. W.: Current concepts in management of snakebite. Milit. Med. 126:526-531, 1961.
21. Dicus, D. R.: Current status of treatment of poisonous snakebite. Postgrad. Med. 31:275-283, 1962.
22. Stahnke, H. L.: The L-C treatment of venomous bites or stings. Amer. J. Trop. Med. 2:142-143, 1953.
23. Stahnke, H. L.: Sunday Edition of Arizona Days and Ways. April 3, 1960.
24. Mullins, J. F. and Naylor, D.: Successful management of cobra bite with cryotherapy. JAMA 174:1677-1679, 1960.
25. Lockhart, W. E.: Treatment of snakebite. JAMA 193:336-338, 1965.
26. Lockhart, W. E.: Snakebite. In "Current Therapy," H. F. Conn, ed., Philadelphia and London, W. B. Saunders, 1969, pp. 876-878.
27. Wood, J. T.: Critique on "L-C" treatment of snakebites. Southern Med. J. 49:749-751, 1956.
28. Genarro, J. F., Jr.: Observations on the treatment of snakebite in North America. In: "Venomous and Poisonous Animals and Noxious Plants of the Pacific Region." H. I. Keegan and W. V. MacFarlane, eds., Pergamon Press, Oxford, 1963, pp. 427-449.
29. Schottler, W. H. A.: Antihistamines, ACTH, cortisone, hydrocortisone and anesthetics in snakebite. Amer. J. Trop. Med. 3:1083-1091, 1954.
30. Russell, F. E. and Emergy, J. A. Effects of corticosteroids on lethality of A. contortrix venom. Amer. J. Med. Sci. 241:507-511, 1961.
31. Russell, F. E.: Effects of cortisone during immunization with Crotalus venom. Toxicon 3:65-67, 1965.
32. Allen, F. M.: Mechanical treatment of venomous bites and wounds. Southern Med. J. 31:1248-1253, 1938.
33. Allen, F. M.: Observations on local measures in the treatment of snakebite. Amer. J. Trop. Med. 19:393-404, 1939.
34. Parrish, H. M.: Early excision and suction of snakebite wounds in dogs. N. Carolina Med. J. 16:93-96, 1955.
35. Snyder, C. C., Pickins, J. E., Knowles, R. P., Emerson, J. L. and Hines, W. A.: A definitive study of snakebite. J. Florida Med. Assn. 55:330-337, 1968.
36. Huang, T. T., Lynch, J. B., Larson, D. L. and Lewis, S. R.: The use of excisional therapy in the management of snakebite. Ann. Surg. 179:598-607, 1974.
37. Glass, T. G., Jr.: Cortisone and immediate fasciotomy in the treatment of severe rattlesnake bite. Texas Med. 65:7-13, 1969.
38. Henderson, B. M. and Dujon, E. G.: Snakebites in children. J. Pediat. Surg. 8:729-733, 1973.
39. Borden, J., Fonkalsrud, E. W., Newcomer, V. D., Rochlin, D. B. and Longmire, W. P. Jr.: Snakebite: Treatment by isolation perfusion technique. Surgery 49:303-307, 1961.
40. Homma, M. and Tu, A. T.: Antivenin for the treatment of local tissue damage due to envenomation by Southeast Asian snakes: Ineffectiveness in the prevention of local tissue damage in mice after envenomation. Amer. J. Trop. Med. Hyg. 19:880-884, 1970.
41. Russell, F. E., Ruzic, N. and Gonzalez, H.: Effectiveness of Antivenin (Crotalidae) Polyvalent following injection of Crotalus venom. Toxicon 11:461-464, 1973.
42. Parrish, H. M. and Kahn, M. S.: Snakebite during pregnancy. Obstet. Gynec. 27:468-471, 1966.
43. Ledbetter, E. O. and Kutscher, A. E.: The aerobic and anaerobic flora of rattlesnake fangs and venom. therapeutic implications. Arch. Environ. Health 19:770-778, 1969.
44. Purana nanda, C.: Treatment of snakebite cases in Bangkok. In: "Venoms," E. E. Buckley and N. Porges, eds., Publ. #44 of the American Association for the Advancement of Science, Washington, D.C., 1956, pp. 353-358.

Acknowledgement

I would like to express my great appreciation for the assistance and patience of my secretary, Ms. Lisbeth Van Wyk, who typed the several drafts of this paper.

ADDENDUM

After submission of the manuscript the following excellent article was brought to my attention:

Russell, F. S.; Carlson, R. W.; Wainschel, J., and Osborne, A. H.: Snake Venom Poisoning in the United States, JAMA 233:341-344, 1975.

▶ Dr. Van Mierop, Department of Pediatrics (Cardiology), University of Florida College of Medicine, Gainesville 32610.

Reprints are available from the author.

EDITORIAL COMMENTS

The biological background of venomous snakes is a fascinating subject for the biologist and provides an interesting discussion of poisonous snakes. Various components of snake venom, although to my knowledge, have not been broken into the various components, and their effect on the human body, may provide an indication for treatment. Some patients respond with a reduction in their prothrombin time and platelets, and the correction of these make for a logical form of treatment in these specific cases. Although some sudden deaths have occurred from fright, there are other components such as so-called bradykinin, which can affect the human and substantiate a strong indication for hospital admission for what may appear to be a relatively innocuous snake bite.

As further knowledge of allergic reactions unfold, it may well be that the more adequate treatment of snakebite will lie in the field of "Allergy." At the present time, treatment of snakebite can very well necessitate a team effort, as a snakebite with maximum envenomation can result in treatment that is not unlike a severe burn with attention to blood volume. The decision as to the time to do fasciotomies, requires close cooperation between surgical and medical divisions.

Doctor L. H. S. Van Mierop deserves to be complimented on his complete study in review of the subject.—Carl E. Andrews, M.D., West Palm Beach

This is a well done, lengthy paper on snakebite dealing with the etiologic factors in a specific way. It is fairly comprehensive and should provide useful information for the clinician and experienced layman. The treatment for snake envenomation in North America is a clearly written review of accepted modes.—Joseph F. Gennaro Jr., M.D., New York University, New York.

A scholarly review of the subject and worthy of publication.—Neil Abramson, M.D., Jacksonville.

This paper will be of considerable value and interest to laboratory and research workers in the field of envenomation. Table I, Grading of Envenomation should be particularly helpful to the emergency physician.—Henry C. Huntley, M.D., Jacksonville.

This paper reads easily and is quite concise presenting the pertinent aspects of the various types of poisonous snakes and their venom.—Carlton Baker, M.D., Tampa.

Excellent. Much needed review of a subject pertinent to Florida.—Roger Palmer, M.D., Miami.

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That unnerving—and almost incredible—statistic comes from the recently released first Public Health Service survey designed to assess the nutritional status of the *entire U.S. population.**

So when you encounter the apathy, lethargy, irritability and behavior problems that may telegraph such iron deficiency, consider the need for a diet richer in iron. Or, if diet change is impractical, INCREMIN® with Iron Syrup, a remarkably palatable liquid that encourages patient adherence to your instructions.

*First Health and Nutrition Examination Survey, DHEW Pub. No. (HRA) 74-1219-1, National Center for Health Statistics, Rockville, Maryland. (This report indicates that approximately 95% of the children 1-5 years old had iron intakes *below* the standard set by the Food and Nutrition Board of the National Academy of Sciences.)

INCREMIN®

Dietary Supplement

with **IRON** Syrup

Each teaspoonful (5 cc) contains:

Elemental Iron (as Ferric Pyrophosphate)	30 mg
l-Lysine HCl	300 mg
Thiamine HCl (B_1)	10 mg
Pyridoxine HCl (B_6)	5 mg
Vitamin B_{12}	25 mcgm
Sorbitol	3.5 gm
Alcohol	0.75%

DOSAGE: Prevention of iron-deficiency anemia—Children and Adults —1 tsp. (5 cc) daily. Treatment of iron deficiency anemia—Children: 1 tsp. t.i.d.; Adults: 1 tsp. q.i.d.

SUPPLY: Bottles of 4 fl. oz. and 16 fl. oz.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

Lederle

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CANDIDATES FOR BEMINAL®-500

The Convalescent Patient	X
The Chronically Ill Patient	X
The Geriatric Patient	X
The Postsurgical Patient	X
The Chronic Alcoholic	X





When the need is for therapeutic vitamin B complex with vitamin C, BEMINAL-500 has what it takes

Virtually any patient in need of high potency B complex vitamins with vitamin C is a candidate for BEMINAL-500. The preop, postop, or convalescent patient with increased nutritional demands. The debilitated patient with vitamin deficiencies resulting from long-term illness. The geriatric patient with vitamin deficiencies related to eccentric diet, poor dentition, or reduced absorption from the G.I. tract. The chronic alcoholic whose erratic living habits can lead to serious nutritional deficiencies. BEMINAL-500 Tablets have what it takes to help. And they are odorless and leave no aftertaste.

Each tablet contains:

Thiamine mononitrate (Vit. B_1)	25.0 mg.
Riboflavin (Vit. B_2)	12.5 mg.
Niacinamide	100.0 mg.
Pyridoxine hydrochloride (Vit. B_6)	10.0 mg.
Calcium pantothenate	20.0 mg.
Ascorbic acid (Vit. C), as sodium ascorbate	500.0 mg.
Cyanocobalamin (Vit. B_{12})	5.0 mcg.

Contains 0.15 mg. of saccharin, as sodium saccharin, per tablet.

DOSAGE: *Adults*—1 tablet daily, or as directed by physician.

SUPPLIED: No. 824—BEMINAL-500 Tablets, in bottles of 100.

BEMINAL®-500
THERAPEUTIC VITAMIN B COMPLEX TABLETS WITH 500 mg. VITAMIN C

Ayerst® Ayerst Laboratories New York, N.Y. 10017

7539

ORGANIZATION

Florida Medical Association House of Delegates

Interium Meeting

January 29 - February 1, 1976

Orlando

First House of Delegates

The First House of Delegates convened at 2:15 p.m. on Friday, January 30, 1976, at the Orlando Hyatt House, Orlando, with Dr. Louis C. Murray, Speaker of the House presiding.

The invocation was given by Dr. Jack Q. Cleveland, Past President, Coral Gables, Florida.

Dr. Donald G. Nikolaus, Chairman of the Credentials Committee reported that a quorum of 198 delegates were present and that 38 counties were represented, constituting a quorum. Dr. Nikolaus moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—Owen F. Agee, Henry J. Babers Jr., George J. Caranasos, William B. Deal, Gerold L. Schiebler (Absent—Stanley I. Cullen)
BAY—B. Phillip Cotton, James D. Phillips.
BREVARD—Lewis A. Bean, Michael J. Foley, T. John Kaminski, Laudie E. McHenry, Pat B. Unger.
BROWARD—Robert J. Brennan, B. B. Burgess, Andre S. Capi, Burns A. Dobbins Jr., James A. Jordan, Alex E. Molchan, Ray E. Murphy, F. B. Ott, James B. Perry, Thomas F. Regan, J. M. Sachs, N. W. Skaja, Stratton N. Sterghos, Anthony J. Vento, W. D. Wells, Juan A. Wester, James C. Woulff (Absent—Robert L. Andreae, Charles H. Bechert II, T. W. Hahn, David C. Lane, Arthur I. Segaul).
CAPITAL—N. H. Kraeft, J. W. MacDonald, R. N. Webster, R. P. Johnson.
CHARLOTTE—(Absent—Fred P. Swing, Melvyn Katzen).
CITRUS-HERNANDO—W. Randall Jenkins.
CLAY—Laurin G. Smith.
COLLIER—Ed Dean, Nick Kalvin.
COLUMBIA—(Absent—Frank Adel).
DADE—Jerome Benson, Rufus K. Broadaway, Luis A. Cabrera, John Cunio, Manuel L. Carbonell, Edmund Cava, Jack Q. Cleveland, Vincent P. Corso, O. William Davenport, Joseph H. Davis, Charles A. Dunn III, Miguel Figueroa, Joseph H. Fitzgerald, Humberto Fontana, Ralph Frankel, Raul Galliano, Stephen Glucroft, Harold S. Goldstein, L. M. Goldstein, Milton Goldman, Pedro J. Greer, Julian H. Groff, Henry Hardin, Joan Harris, Joseph Harris, Robert B. Katims, C. G. Llanes, S. D. Mitchel, Jorge Pena, Oscar Sandoval, Daniel L. Seckinger II, J. K. Sherwood, Margaret Skinner, S. P. H. Stokley, C. M. Stone Jr., Mario M. Stone, William M. Straight, C. R. Tate, M. F. Taylor, Thomas B. Turner, John C. Turner, Edgar W. Webb, Bruce Weissman, Robert E. Willner, Sheldon Zane (Absent—William G. Aten, R. C. Clay, R. C. Dever, Isaac Egozi, Franklin J. Evans, A. J. Fernandez Conde, Ivor Fix, M. F. Hall, W. C. Jones III, James Jude, B. G. Lary, R. J. Mann, Bruce E. Miller, M. A. Mora, Everett Shocket, Thomas J. Noto Jr., Elliot Witkind).
DESOTO-HARDEE-GLADES—Calvin W. Martin.
DUVAL—S. J. Alford Jr., Warren M. Barrett, James L. Borland Jr., Yank D. Coble Jr., Clyde M. Collins, Patricia C. Cowdery, Samuel M. Day, Thomas S. Edwards, Walter G. Jarrell, John C. Kruse, Sanford A. Mullen, John A. Rush Jr., William D. Walklett, (Absent—Emmet F. Ferguson Jr., William J. Garoni Jr., Charles P. Hayes Jr., Guy T. Selander).
ESCAMBIA—W. Reed Bell, Eric F. Geiger, Theodore J. Marshall, Nell W. Potter, John H. Whitcomb.
FRANKLIN-GULF—Joseph P. Hendrix.
HIGHLANDS—Donald C. Hartwell.
HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Irving M. Essrig, John C. Fletcher, Carlisle Hewitt, Richard S. Hodes, Victor Knight, Thomas E. McKell, W. Mahon Myers, Ralph M. Stephan, John F. Petrakis, William W. Trice, Harold L. Williamson.
INDIAN RIVER—John H. Terry (Absent—B. F. Sowell)
LAKE—B. F. Brokaw, Ernest Wollin.
LEE—Larry Garrett, Stewart Hagen III, F. Lee Howington.
MADISON—(Absent—William J. Bibb).
MANATEE—Thomas R. Busard, John D. Lehman, Roger A. Meyer.
MARION—C. Brooks Henderson, Samuel L. Renfroe.
MARTIN—Richard Q. Penick, (Absent—John F. Powers).
MONROE—(Absent—William M. Whitley, J. J. Weinstock).
NASSAU—Theodore G. Panos.
OKALOOSA—William M. Thompson, Eugene R. Valentine.

ORANGE—Francis M. Coy, William F. Eckbert, Edward L. Farrar Jr., Clarence M. Gilbert, Rufus M. Holloway, Paul C. Harding, G. Brock Magruder, Joseph G. Matthews, Franklin B. McKechnie, Edward W. Stoner, Thomas B. Thames, Robert B. Trumbo (Absent—F. G. Norris).
OSCEOLA—George A. Gant.
PALM BEACH—Carl Andrews, Curtis W. Cannon, J. Russell Forlaw, Luis Guerrero, Doris E. Lake, Charles Metzger, Richard B. Moore, Thomas Murphy, Reginald Stambaugh, A. L. Trask, Dick Van Eldik, Harold Yount.
PANHANDLE—Herbert E. Brooks, William F. Brunner.
PASCO—M. L. Saperstein.
PINELLAS—Charles K. Donegan, Irwin L. Entel, John M. Hamilton, Kay Hanley, Daniel S. Hellman, David S. Hubbell, Morris J. LeVine, Jack A. MaCris, Donald G. Nikolaus, David T. Overbey, Howard L. Reese, Walter H. Winchester, Joseph M. Worth (Absent—Walter W. Hamilton).
POLK—Sam J. Barranco, Marvin G. Burdette, T. M. Caswall, J. G. Converse, John W. Glotfelty, W. E. Manry Jr., Frank Zeller Jr.
PUTNAM—(Absent—Charles E. Barrineau).
ST. JOHNS—Wayne O'Connell
ST. LUCIE-OKEECHOBEE—William H. Meyer.
SANTA ROSA—William N. Watson.
SARASOTA—John N. Carlson, K. C. Kiehl, Douglas R. Murphy, Franklin H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.
SEMINOLE—Clyde K. Meade (Absent—John Johnson).
SUWANNEE-HAMILTON-LAFAYETTE—L. V. Radkins Jr.
TAYLOR—John H. Parker Jr.
VOLUSIA—O. B. Bonner, Richard L. Dillard, Michael Fronstin, Richard W. Snodgrass, Thomas L. Wells.
WALTON—(Absent-Howard Currie).
SPEAKER OF THE HOUSE—Louis C. Murray.
VICE SPEAKER—Charles J. Kahn.

Upon motion duly carried, the Rules and Order of Business of the House were adopted as follows:

Information for Delegates

The Rules and Order of Business for the Interim Meeting of the House of Delegates is included in this Handbook.

Delegates whose names appear in this Handbook are those seated at the 1975 Annual Meeting. Replacements must be certified by their county medical societies. Our Bylaws do not permit an alternate to serve for a delegate who has once been seated. The Bylaws require that delegates fill out attendance cards at each **meeting** of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and/or recommendations to be considered during the Interim Meeting are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House.

All reports will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any report should attend the Reference Committee meetings where a full discussion will take place. All members of Reference Committee meetings are urged to study carefully the reports referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates.

All reports included in this Handbook have been color coded for easy reference. This color code is as follows:

REFERENCE COMMITTEE NO. I—Pink

REFERENCE COMMITTEE NO. II—Blue

Your Speaker and Vice Speaker are available at any time in any capacity in which they might help any member or the Florida Medical Association.

Louis C. Murray, Speaker
House of Delegates
Charles J. Kahn, Vice Speaker
House of Delegates

The Speaker introduced the officers of the Association: Drs. Vernon Astler, President; Jack A. MaCris, President-Elect; Thad Moseley, Immediate Past President, Irving M. Essrig, Vice President; James W. Walker, Secretary; Richard S. Hodes, Treasurer; Charles J. Kahn, Vice Speaker; and W. Harold Parham, D.H.A., Executive Vice President.

The Speaker then instructed the House.

Remarks of the Speaker

President Astler, Officers, Delegates, and Members of the Florida Medical Association, my remarks today will be quite brief and to the point in view of the extreme importance of turning our attention to the critical matters which have necessitated calling this Interim Session of the House of Delegates. The subject matter is strictly limited to the items on your agenda. Your decisions should be firm and unified after the presentation of your reference committees on Sunday. All delegates wishing to present positions are urged to attend the reference committee meetings and participate fully. Then Sunday, let us hope for the development of an action program in the area of proposed professional liability insurance legislation and other matters, and that you will return to your various counties and put your time, mind, and resources behind the implementation of what you decide here. I would desire that this session be thought of as—ACTION '76—toward creating an atmosphere conducive to the continued quality health care of our patients.

Dr. Murray then presented the President, Dr. Vernon B. Astler, who delivered his address to the House:

Mr. Speaker, Officers, Fellow Delegates, Members and Guests:

It is a valid observation that physicians are publicly on the defensive. While the posture is not appealing to me, it is particularly true in the political arena. This observation is compounded at the state level by the fact that our annual business and scientific meeting has been held in May. Obviously, most of the legislative effort and action has already occurred by this date and we physicians are left with the defensive modalities of criticizing that which has past, or recommending changes for the following year. Common sense dictates the difficulty in striking or reversing a law compared to blocking or altering the law by various means before it has become fait d'accompli; therefore, I called this special meeting of the House of Delegates this month to try to arrange our legislative package and efforts well in advance of the legislative session. The Board of Governors wisely limited the session to items particularly pertinent to these endeavors, plus a limited number of other matters deemed to be of sufficient

import to be placed on this agenda; therefore, all other matters may be handled at our annual meeting in May at the Diplomat Hotel and will not be considered here.

It has been my conviction that in Florida, as well as nationally, physicians have fared poorly at the hands of politicians and bureaucrats. We were not trained or skilled in these matters and therefore entered the arena as novices; many of us were too busy caring for patients, attending scientific programs, meeting hospital staff requirements, and completing never-ending mountains of paper work (imposed upon us by the same politicians and bureaucrats) to rationally protect the best interests of our patients and our profession.

I, therefore, pledged to overhaul our legislative and political endeavors. It is practical that we outline immediate or short-range objectives as well as long-range objectives. Your President-Elect, Jack MaCris, has wisely indicated his concern with one long-range program and has established a committee to this end. This committee will concern itself with matters such as review of the tort system in the medical liability area, possible use of "no fault" and Workmen's Compensation type approaches, and many others.

I have outlined to the Florida Medical Liability Insurance Commission possible legislative change which could be enacted this year to curtail the spiraling costs of PLI, realizing these costs ultimately come from our patient's pocketbooks, the Board of Governors appointed a committee headed by Dr. William Dean, St. Petersburg, who, in no small way, helped to develop many of these concepts. The committee received input, not only from their own committee, but from all other knowledgeable sources that they could reach.

This list might well serve as a starting point during these deliberations to mold an effective legislative effort. Included were: (1) Provisions for recovery of defense costs in unsuccessful suits, (2) The use of a compensation panel to determine the amount of damages to be awarded plus a definite cap for general damages, (3) Structured settlements of awards and legal fees, (4) Statutory definition of malpractice, (5) Collateral source benefits applied against settlements, (6) Prohibition against expert witnesses not licensed and practicing in the State of Florida, (7) Two year Statute of Limitations from date of incident, (8) Res Ipsa Loquitur statute providing that injury alone does not presume negligence, (9) Negligence to be determined by a panel of knowledgeable professionals rather than by a jury, and (10) Limitation of contingency fees. I also urge that the commission oppose: (1) Mandatory Joint Underwriters Association, (2) Mandatory Patients Compensation Fund, and (3) Mandatory Patient Rehabilitation Fund. Each of these matters must be considered in the context of their value in limiting the number of cases or the amount of excessive settlements. They must also be considered with regard to their likelihood of passage.

It also came as no surprise that our Public Relations Program has been historically weak and disorganized and, therefore, I envisioned some needed reform in this area. To this end, we have already "beefed up" our Tallahassee office by: (1) Hiring Mr. John French as full time legal counsel and lobbyist for the FMA in Tallahassee, (2) Hiring Mrs. Nancy Moreaux, a full-time legislative analyst and advisor, (3) Hiring Mr. George Palmer as our Tallahassee office manager with Mr. Scotty Fraser and (4) Hiring additional secretarial and clerical help. We have also purchased and planned the renovation of a new downtown property which is a centrally located, first floor street level building of adequate size and super location to allow us to move from our overcrowded fourth floor cubby-hole.

What about public relations? A Roper Poll last year asked persons what made up their minds on critical controversial issues—Radio, Newspaper, TV, Magazines, or talking to friends and neighbors. Over 60% listed TV, followed by a weak second place vote of 19% for Newspapers. It seems obvious that we need TV exposure if we are to persuade the public to become our allies. Your Board of Governors, therefore, approved funds to engage Mr. Roy Pfautch of Civic Services Inc., St. Louis, Missouri to carry out an indepth survey and poll in Florida to determine facts concerning physicians, our image, our short-comings, and to sense the public mood regarding the liability crisis and what we can do about these matters. Mr. Pfautch was placed upon a rigid time schedule and asked to report to you delegates at this meeting. He is with us today and I feel you will understand the wisdom of this decision and the need for further action after you have heard him speak.

Fellow delegates, to mount an effective statewide legislative and public relations campaign requires funding, while inflation has increased our operating costs many times in recent weeks, we have managed to keep our budget sensible and balanced. But now additional monies must become available if we are to survive as an effective professional body. In other words, what we decide here

at this meeting shall certainly fashion our destiny and may well preserve our profession and system of organized medicine as we have inherited it and known it during our professional lives.

I need not convince you that there is a direct correlation between legislative and public relations effectiveness and the funding underlying such programs. You have only to look at the relative clout of roughly 600 chiropractors in Florida, whom I am told unofficially contribute $1,000 annually, to recognize the validity of this concept.

I should also warn you of a newspaper clipping I read several weeks ago indicating the national trial lawyers assessment of $1,000 each for a legislative war chest.

While I realize the unpopularity associated with a President asking members to assess themselves, I feel a $100 assessment is the very minimum amount necessary to effectively carry out our objectives. I would strongly urge that these funds be specifically escrowed for public relations and legislative efforts and not to be used or assigned for any other purposes. The hour is late, the situation is urgent. The legislature is not going to revisit the medical liability crisis on an annual basis ad infinitum, but they do intend to review and make necessary changes this year. We ask this money to wage an effective campaign to improve our public relations and credibility in addition to achieving necessary legislative relief if the free enterprise health delivery system as you and your patients have known it is to survive. If you defeat the proposal you defeat yourselves.

Thank You.

Dr. Astler, President, introduced Mr. Roy Pfautch, Civic Services, Inc., who gave a slide presentation of the findings of a public relations survey he had been retained to do for the FMA. The survey concentrated on the public's image of the physician in Florida. A summary of his remarks regarding this indepth study follows:

A REVIEW OF THE BASIC FINDINGS:

Sentiment for doctors quite good . . . respected.

Sentiment for health care not so good because many feel advances of health care are not possible for them . . . primarily because of economic reasons.

Considerable fear over threat of major illness.

Economic crunch the major worry in health care.

Some degree of economic finger-pointing at doctors who are perceived as making a great deal of money and causing the high price of health care.

Government seen as prime mover/solver of the health care issue.

Malpractice issue very salient, quite conscious to the public.

Malpractice issue seen as threat to health care.

Malpractice issue seen as threat to personal relationship between physician and patient which is still regarded as very important.

Malpractice issue seen as only start . . . medicine is first on attack line.

Willingness of respondents to help doctor in this issue crisis.

Greed factor on part of those who sue perceived.

Unique consensus of opinion across many lines in support of doctor.

Possibility of education campaign very viable. Determination of what organized medicine wishes to accomplish is key will decide nature and scope of campaign . . . but sentiment is there for effort.

Health care issue is in mind, is in flux, is present with a degree of uncertainty and worry . . . there will be movement in and on the issue whether organized medicine acts or not.

The Speaker assumed the Chair and announced the corrections in the Handbook for Delegates as follows:

On Page 3 and Page 5, the Chairman of Reference Committee No. II is listed as J. Wayne Hendrix. This was in error and should read Joseph P. Hendrix.

On Page 10, Escambia County should list 5 delegates, rather than 6. Dr. Kahn should not be listed as an Escambia Delegate.

On Page 11, Pasco County should list 1 delegate, rather than 2. Dr. W. R. Jenkins should not be listed as a Pasco delegate.

The Speaker announced that the members of the Reference Committees are published in the Handbook. He announced that Charles A. Dunn III had replaced Everett Shocket on Reference Committee No. I. Dr. Murray advised that copies of the Reference Committee reports would be available on Sunday morning, and he announced the Chairmen of the Reference Committees and their members.

Reference Committee No. I—Legislation
Sanford A. Mullen, Chairman
Jack W. MacDonald
Harold Williamson
Robert J. Brennan
Charles A. Dunn III

Reference Committee No. II—Miscellaneous Business
Joseph P. Hendrix, Chairman
John Fletcher
Richard B. Moore
William M. Straight
Clarence Gilbert

The Vice Speaker, Dr. Kahn, announced the meetings of the Reference Committees on Saturday, January 31, and the time and place of each meeting:

Reference Committee No. I—Legislation
9:00 a.m., Boca/Cocoa Room
Reference Committee No. II—Miscellaneous Business
9:00 a.m., Ft. Lauderdale Room

The Vice Speaker advised that if there was no objection reports would be assigned as published in the Handbook. No objection was raised. The House's attention was called to the referral of the supplemental report which had been distributed in

the Delegates' packets, Report 76-IM-4 "Position Regarding Medical Professional Liability." This report was referred to Reference Committee No. I.

The House voted unanimously to consider a resolution presented by Pinellas County Medical Society entitled "Health Compensation Act." This resolution was referred to Reference Committee No. I.

The Speaker, Dr. Murray, introduced Dr. James W. Walker, President, PIMCO, to speak to the House regarding the FMA-PLI-Trust.

Dr. Walker stated that the Board of Governors had directed that at such time when 1,000 applications had been approved, the Trust would be activated. These 1,000 applications were approved, and the Trust was begun on December 1, 1975. Dr. Walker advised that to-date, the Trust has received approximately 5,000 applications and over 4,000 have been approved.

Dr. Walker stated that the Trust has had cooperation from the county medical societies throughout the state and their committees have spent long, hard hours reviewing every application and recommending acceptance or rejection into the Trust. It was pointed out that the applications are reviewed in Jacksonville by underwriters of FMA, and by Lloyd's of London, and referred to the Trustees for final determination as to the acceptability of a member into the Trust.

Dr. Walker advised that the formation of the company is well underway. The Trust has employed a full-time claims coordinator and full-time legal counsel who will be charged with the responsibility or risk management and claims coordination. Under the auspices of the FMA, consultants have been selected in areas throughout the state in several specialties to serve as team leaders of consultant review teams. It will be the function of this group to review the appeals of applicants who have been declined coverage by the Trustees, to look at suits as they come in, and advise the claims coordinator as to the defensibility of a suit, to help arrange testimony, and to arbitrate any disagreement between any member of the Trust and the Trustees when it comes to the settlement of a suit.

The Speaker, Dr. Murray advised that the Chair had decided on a point of privilege and requested the Executive Vice President, Dr. W. Harold Parham, to speak to the House. Dr. Parham advised the House that the FMA had recently negotiated with an automobile leasing company, to secure an automobile leasing program for FMA members. He stated that Jack Nicklaus Leasing Company, Delray Beach, Florida had been contacted and the plan will go into effect as soon as satisfactory arrangements have been made.

The Speaker recognized Mrs. C. B. Henderson, President of the Woman's Auxiliary/FMA, for her many contributions to the FMA.

The Speaker announced the Flampac Board and Executive Committee meeting on Saturday, January 31. He also announced that the General Session on Saturday at 2:00 p.m. would feature Guest Speaker Congressman Robert H. Michel, Illinois and a PLI Panel with Senator Kenneth A. Plante and Rep. J. Hyatt Brown.

The Speaker advised that the Second House of Delegates would meet Sunday, February 1, 9:00 a.m. in the Orlando Hall and recessed the House at 4:55 p.m.

Second House of Delegates

The second meeting of the House of Delegates convened at 9:30 a.m., Sunday, February 1, 1976, at the Orlando Hyatt House, Orlando, with Dr. Louis C. Murray, Speaker of the House, presiding.

Dr. Donald G. Nikolaus, Chairman of the Credentials Committee, reported that 220 delegates were present, constituting a quorum and that a majority of counties (41) were represented. Dr. Nikolaus moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—Owen F. Agee, Henry J. Babers Jr., George J. Caranasos, William B. Deal, J. Lee Dockery, Gerold L. Schiebler.
BAY—B. Phillip Cotton, James D. Phillips.
BREVARD—Lewis A. Bean, Michael J. Foley, T. John Kaminski, Laudie E. McHenry, Pat B. Unger.
BROWARD—Charles H. Bechert II, Robert J. Brennan, B. B. Burgess, Andre S. Capi, Burns A. Dobbins Jr., T. W. Hahn, James Jordan, David C. Lane, Alex E. Molchan, Ray E. Murphy Jr., F. B. Ott, James B. Perry, Thomas F. Regan, J. M. Sachs, Diran M. Seropian, N. W. Skaga, Stratton N. Sterghos, Anthony J. Vento, W. D. Wells, Juan A. Wester, James C. Woulff (Absent —Arthur I. Segaul).
CAPITAL—R. P. Johnson, N. H. Kraeft, J. W. MacDonald, R. N. Webster.
CHARLOTTE—Melvyn Katzen, Fred P. Swing.
CITRUS-HERNANDO—W. Randall Jenkins.
CLAY—Laurin G. Smith.
COLLIER—Ed Dean, Nick Kalvin.
COLUMBIA—B. E. McRae.
DADE—Ed Annis, William G. Aten, Jerome Benson, Rufus K. Broadaway, Luis Cabrera, John Cunio, Manuel L. Carbonell, Edmund Cava, R. C. Clay, Jack Q. Cleveland, Vincent P. Corso, O. William Davenport, Joseph H. Davis, R. C. Dever, Charles A. Dunn III, Franklin J. Evans, Miguel Figueroa, Joseph H. Fitzgerald, Humberto Fontana, Ralph Frankel, Raul Galliano, Norman Gottlieb, Stephen Glucroft, Harold S. Goldstein, L. M. Goldstein,

Milton Goldman, Pedro J. Greer, Julian H. Groff, Henry Hardin, Joan Harris, Joseph Harris, James Jude, Robert B. Katims, B. G. Lary, C. G. Llanes, S. D. Mitchel, M. M. Mora, Harold Norman, Thomas J. Noto Jr., Jorge Pena, Oscar Sandoval, Ronald Scherr, Daniel L. Seckinger II, J. K. Sherwood, Margaret Skinner, Everett Shocket, S.P.H. Stokley, C. M. Stone Jr., Mario M. Stone, William M. Straight, C. R. Tate, M. F. Taylor, Thomas B. Turner, John C. Turner, Edgar W. Webb, Bruce Weissman, Sheldon Zane (Absent—A. J. Fernandez Conde, Ivor Fix, M. F. Hall, W. C. Jones III, Robert E. Willner).

DESOTO-HARDEE-GLADES—Calvin W. Martin.

DUVAL—S. J. Alford Jr., Warren M. Barrett, James L. Borland Jr., Yank D. Coble Jr., Clyde M. Collins, Patricia C. Cowdery, Samuel M. Day, Thomas S. Edwards, Emmet F. Ferguson Jr., Charles P. Hayes Jr., John C. Kruse, Sanford A. Mullen, John A. Rush Jr., Guy T. Selander, William D. Walklett (Absent—William J. Garoni Jr., Walter G. Jarrell).

ESCAMBIA—W. Reed Bell, Eric F. Geiger, Theodore J. Marshall, Nell W. Potter, John H. Whitcomb.

FRANKLIN-GULF—Joseph P. Hendrix.

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Louis E. Cimino, Frank C. Coleman, Irving M. Essrig, John C. Fletcher, Carlisle Hewitt, Richard S. Hodes, Victor Knight, Thomas E. McKell, W. Mahon Myers, Ralph M. Stephan, John F. Petrakis, William W. Trice, Harold L. Williamson.

INDIAN RIVER—John H. Terry (Absent—B. F. Sowell).

LAKE—B. F. Brokaw, Ernest Wollin.

LEE—Larry Garrett, Stewart Hagen III, F. Lee Howington.

MADISON—(Absent—William J. Bibb).

MANATEE—Thomas R. Busard, John D. Lehman, Roger A. Meyer.

MARION—C. Brooks Henderson, Samuel L. Renfroe.

MARTIN—Richard Q. Penick (Absent—John F. Powers).

MONROE—(Absent—J. J. Weinstock, William M. Whitley).

NASSAU—Theodore G. Panos.

OKALOOSA—William M. Thompson, Eugene R. Valentine.

ORANGE—Francis M. Coy, William F. Eckbert, Edward L. Farrar Jr., Clarence M. Gilbert, Rufus H. Holloway, Paul C. Harding, G. Brock Magruder, Joseph G. Matthews, Franklin B. McKechnie, Edward W. Stoner, Thomas B. Thames, Robert B. Trumbo (Absent—F. G. Norris).

OSCEOLA—George A. Gant.

PALM BEACH—Carl Andrews, Curtis W. Cannon, J. Russell Forlaw, Luis Guerrero, Doris E. Lake, Charles Metzger, Richard B. Moore, Reginald Stambaugh, A. L. Trask, Dick Van Eldik, Harold Yount, (Absent—Thomas Murphy).

PANHANDLE—Herbert E. Brooks, William F. Brunner.

PASCO—M. L. Saperstein.

PINELLAS—Charles K. Donegan, Irving L. Entel, John M. Hamilton, Walter A. Hamilton, Kay Hanley, Daniel S. Hellman, David S. Hubbell, Morris J. LeVine, Jack A. MaCris, Donald G. Nikolaus, David T. Overbey, Howard L. Reese, Walter H. Winchester, Joseph M. Worth.

POLK—Marvin G. Burdette, T. M. Caswall, J. G. Converse, John W. Glotfelty, W. E. Manry Jr., Frank Zeller Jr., (Absent—Sam J. Barranco).

PUTNAM—Charles E. Barrineau.

ST. JOHNS—W. Wayne O'Connell.

ST. LUCIE-OKEECHOBEE—William H. Meyer.

SANTA ROSA—William N. Watson.

SARASOTA—John N. Carlson, K. C. Kiehl, Douglas R. Murphy, Franklin H. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.

SEMINOLE—Clyde K. Meade, Luis M. Perez.

SUWANNEE-HAMILTON-LAFAYETTE—L. V. Radkins Jr.

TAYLOR—John H. Parker Jr.

VOLUSIA—O. B. Bonner, Richard L. Dillard, Michael Fronstin, Richard W. Snodgrass, Thomas L. Wells.

WALTON—(Absent—Howard Currie)

SPEAKER OF THE HOUSE—Louis C. Murray.

VICE SPEAKER—Charles J. Kahn.

Report of Reference Committee

No. I

Legislation

The Speaker called for the report of Reference Committee No. I, Legislation.

Dr. Sanford A. Mullen, Chairman, and his committee came forward to present the report of the Reference Committee.

Dr. Mullen:

"The Committee was most appreciative of the presentation made by James B. Perry, M.D., Chairman of the Council on Legislation and Regulations, and by John C. Kruse, M.D., Chairman of the Committee on State Legislation. Dr. Perry and Dr. Kruse remained throughout the meeting and were very helpful in answering questions and explaining the plans for legislative activities.

"Your Committee would like to give public recognition for the outstanding work Dr. Perry and Dr. Kruse have performed on behalf of the Florida Medical Association in the various legislative programs. We would also like to pay tribute to George S. Evans, M.D., who preceded Dr. Kruse as Chairman of the Committee on State Legislation until he submitted his resignation when he moved his practice from Florida in November 1975. We would like to recognize the effective and diligent work of Mr. Donald S. Fraser, Jr., Director of Public Affairs at the FMA Tallahassee office. Your Committee has been favorably impressed by the work of Mr. George S. Palmer, Jr., Manager of the FMA Tallahassee office, and Mrs. Nancy Moreau, legislative analyst. Mrs. Gail Ricks and Mrs. Diane Malone of the Capital Office staff have provided excellent support for the FMA program. We commend the leadership of the FMA for the recent appointment of Mr. John H. French as the legislative counsel for the FMA.

"Your Reference Committee would like to take this opportunity to also commend Dr. William J. Dean of St. Petersburg, a Past President of the FMA, who chaired a special committee of the Board of Governors on Professional Liability Legislation. The report of Dr. Dean's committee was enthusiastically accepted by the Board and has formed the basis for the FMA legislative program."

REPORT OF THE BOARD OF GOVERNORS

Supplemental Report No. 76-IM-4

Position Regarding Medical Professional Liability

The Reference Committee amended several items outlined in the report as follows.

The Committee made comments concerning the specific items in the proposed FMA legislative program for professional liability insurance contained in the report. The Committee recognized that any legislative program is ongoing and continually changing and that we have the utmost confidence in our legislative representatives and do not want to restrict them in their efforts to correct the problems which we face in the field of professional liability. For this reason the committee recommended to the House of Delegates that the proposed program be in the form of broad guidelines.

The recommendation of the Reference Committee was adopted.

Item 1

Upon recommendation of the Reference Committee, Item 1 of the report was adopted.

Item 2

The Reference Committee recommended that Item 2 of the report be changed to read, "a) A mediation panel with valid constitutional status to make determinations as to medical negligence and to provide a basis for awards of damages, and b) A limitation on the amount of general damages which may be awarded."

The recommendation of the Reference Committee was adopted.

Item 3

Upon recommendation of the Reference Committee, Item 3 of the report was adopted.

Item 4

Upon recommendation of the Reference Committee, Item 4 of the report was adopted.

Item 5

Upon recommendation of the Reference Committee, Item 5 of the report was adopted.

Item 6

The Reference Committee recommended that Item 6 of the report be changed to read, "A statutory definition of medical expert witnesses."

The recommendation of the Reference Committee was adopted.

Item 7

Upon recommendation of the Reference Committee, Item 7 of the report was adopted.

Item 8

The Reference Committee recommended that Item 8 of the report be changed to read, "A prohibition of the use of **Res ipsa loquitur** in medical liability actions."

The recommendation of the Reference Committee was adopted.

Item 9

The Reference Committee recommended that Item 9 of the report be changed to read, "A limitation of contingency fees paid to attorneys by every reasonable legislative and/or judicial means, including investigation of structuring of contingency fees and limitation of finders' fees."

A motion was made to amend the recommendation by deleting "and limitation of finders' fees" and adding, "and that there be a list of all pleadings of all involved parties."

The motion carried:

The recommendation of the Reference Committee was adopted as amended.

Item 10

Upon recommendation of the Reference Committee, Item 10 of the report was adopted.

Item 11

Upon recommendation of the Reference Committee, Item 11 of the report was adopted.

Item 12

Upon recommendation of the Reference Committee, Item 12 of the report was adopted.

Item 13

The Reference Committee recommended that an Item 13 be added to the report to read, "The principles of the Good Samaritan Law be extended to cover care in which the original patient-physician relationship is initiated in an emergency situation, in or out of the hospital.

The recommendation of the Reference Committee was adopted.

Item 14

The Reference Committee recommended that an Item 14 be added to the report to read, "The Board of Governors is requested to investigate the advisability of seeking legislation which would give 'privileged communications' status to all medical records."

The recommendation of the Reference Committee was adopted.

Upon recommendation of the Reference Committee, Supplemental Report 76-IM-4, "Position Regarding Professional Liability" was adopted as amended.

Report of the Board of Governors
Supplemental Report No. 76-IM-4
Position Regarding Medical Professional Liability

The Florida Medical Association was formed in 1874 as a scientific professional organization dedicated to the advancement of medical science and medical services in Florida. This position has been adopted on behalf of the more than 10,500 physicians of the FMA.

The problem of professional liability insurance coverage and cost has become so intense, it is seriously jeopardizing

the delivery of medical care in this state in various manners: physicians are discontinuing the practice of medicine, leaving the State of Florida to practice medicine elsewhere, or declining to start practicing in Florida; semi-retired physicians are discontinuing limited services in retirement villages; and certain types of medical treatment are being discontinued.

As an Association, our initial experience with medical professional liability insurance was the FMA Group Program which was established in 1929 and continued until the late 1940's. This program was based on a master policy under which individual certificates were issued; it was underwritten by three U.S. companies until shortly after World War II when these companies stopped honoring this group plan.

In the early 1950's the FMA established a special committee which was commissioned to work toward the development of an ideal program containing centralized claims handling, centralized coordination of legal defense, peer review for underwriting, and many other novel features. Eight years were spent seeking a responsible company to underwrite this model program. The Employers Group of Insurance Companies of Boston agreed to underwrite the FMA Professional Liability Insurance Plan effective January 1, 1963. The program had a slow development and low participation until the late 1960's when over 20 companies discontinued writing this type of coverage in Florida and participation boomed.

As the program was reaching its peak in participation and implementation of its special features, the Commercial Union Insurance Companies of England purchased the Employers Group of Insurance Companies and terminated all policies December 31, 1972. Negotiations were completed with the Argonaut Insurance Company of Menlo Park, California, to underwrite this group program beginning January 1, 1973 for a period of five years. In February, 1975 Argonaut, forced by its parent company Teledyne, committed a breach of contract, threatened to terminate every physician by March 1, 1975, and levied an illegal assessment which totaled over $13,000,000 upon the policy holders under this plan. A Federal Court suit resulted over these actions. The Federal Court ruled that the January 1, 1975 premium and individual policies must remain in force until December 31, 1975 and that the illegal assessment be refunded by Argonaut. There was no responsible insurance company which would underwrite the FMA professional liability insurance plan on January 1, 1976 when the Argonaut agreement terminated.

The FMA leadership has acted in a responsible manner by establishing, endorsing and recommending the FMA-Professional Liability Insurance-Trust. It has received over 5,000 applications from members of the Association. The Trustees have adopted a sound course of underwriting based upon the most accurate actuarial data available, have established a management company composed of the most competent people in the insurance field available, and have taken every precaution to make this a sound venture.

To insure medical professional excellence, we are continuing our commitment to strict standards for licensure, approved specialty training, mandatory post graduate education, hospital review and qualification, sponsorship by other physicians, tissue and review committees, and medical peer review. We would like to emphasize that these stringent procedures have all been established from within the medical profession and, further, that no other profession has ever exhibited such self-imposed standards of qualification and review to insure the excellence of its members. The last session of the Florida Legislature has assisted us greatly by giving more powers and responsibilities to the State Board of Medical Examiners.

We believe that every patient who is injured as a result of negligence should be compensated immediately for rehabilitation and damages incurred. Therefore, there is a definite need for professional liability insurance. However, this insurance should not be utilized for life insurance, disability insurance, or health and accident insurance, where no negligence exists, and for which no premium has been paid.

We recognize that the overall problem of professional liability is a social problem and cannot be resolved in one fell swoop. However, the spiraling cost of this insurance is passed on to the patient and must be curtailed before it becomes catastrophic.

We believe the following legislation, if enacted into law, would be of definite advantage in curtailing spiraling costs caused by the frequency of claims and the increasing amounts for damages awarded and defense of unwarranted suits:

1. A provision for recovery of defense costs in unsuccessful suits.
2. a) A mediation panel with valid constitutional status to make determinations as to medical negligence and to provide a basis for awards of damages.
 b) A limitation on the amount of general damages which may be awarded.
3. A structured settlement of awards and legal fees requiring periodic payments rather than a lump sum payment for such future damages and thus Insuring continuous support for the injured patient during his entire disability period.
4. A statutory definition of medical malpractice (negligence).
5. The amount of benefits from any collateral sources to be applied against the total of a settlement in order to rule out duplicate payments.
6. A statutory definition of medical expert witnesses.
7. An absolute two-year statute of limitation from date of incident to permit a realistic actuarial determination of the medical malpractice risk and make it possible for private insurance carriers to reenter the State of Florida.
8. A prohibition of the use of Res ipsa loquitur in medical liability actions.
9. A limitation of contingency fees paid to attorneys by every reasonable legislative and/or judicial means, including investigation of structuring of contingency fees, and that there be a list on all pleadings of all involved parties.
10. We do not believe that a permanent J.U.A. should be considered at the present time when the self-destruct statute was passed only 6 months ago to solve an availability problem. We believe that the formation of the FMA-PLI-Trust and other trusts which have become operational in Florida and supported by the enactment of additional statutory relief will solve the availability problem. In our opinion it would be premature to consider a permanent J.U.A.
11. We believe a mandatory patient's compensation fund, would be a needless form of government intervention; reflect an obvious discrimination against the physician; would be most detrimental to the free enterprise system on which our country was founded; and result in an inequitable tax administered by the state for the privilege to practice medicine. Alternate methods of funding on a broader base should be considered.
12. A careful look must also be taken at the proposed patient's rehabilitation fund to compensate every individual who has an untoward result not based upon any negligence. This would represent a rehabilitation and welfare program which could only result in untold economic proportions.
13. The principles of the Good Samaritan Law be extended to cover care in which the original patient-physician relationship is initiated in an emergency situation, in or out of a hospital.
14. The investigation of the advisability of seeking legislation which would give 'privileged communications' status to all medical records.

The FMA has acted in a responsible and positive manner to help resolve the availability problem; however, the final solution to the problem, which is needed in the immediate future, will come only with the further understanding and assistance of the Florida Legislature directed at curtailing the spiraling costs of professional liability insurance.

Resolution IM-76-1
Health Compensation Act
Pinellas County Medical Society

"The Reference Committee considered Resolution No. IM-76-1, Health Compensation Act, introduced by the Pinellas County Medical Society and heard testimony by members of the Date County Medical Association delegation concerning a plan for patient self-insurance against medical malpractice (copy available at the FMA office). In considering these items, the Committee was quite attracted by the innovative approaches presented in both proposals. The thrust of these would, in essence, be to move medical malpractice from the tort system to a broad-based publicly financed system. Your Committee would be favorably inclined toward approval of these concepts, if they can be determined to be effective and fiscally sound. We do not believe that either plan is in a final stage of development and that additional work must be done on them before they are ready for consideration as a part of the FMA legislative program."

The Reference Committee recommended that these items (plans for patient self-insurance against medical malpractice, the thrust of which would be to move medical malpractice from the tort system to a broad-based publicly financed system) be referred to the Board of Governors for study with a report and recommendations to be given to the House of Delegates at the 1976 Annual Meeting.

A motion was made to amend the recommendation deleting "with a report and recommendations to be given to the House of Delegates at the 1976 Annual Meeting" and adding "and if possible, implementation in the 1976 Legislature."

The motion carried.

The recommendation of the Reference Committee was adopted as amended.

Resolution IM-76-1
[Not Adopted—Referred to the Board of Governors]
Health Compensation Act

Whereas, The laws of tort as they relate to the practice of medicine exist to improve the quality of medical care, in reality today the tort laws reduce the quality of medicine practice, and

Whereas, The present malpractice system severely retards the continuing education of physicians and surgeons, and

Whereas, The present system erodes the physician-patient relationship, and

Whereas, The primary principle by which medicine is practiced (thou shall do no harm) is in serious jeopardy by the alarming increase in suits pertaining to failure to diagnose; therefore be it

RESOLVED, That the major legislative efforts of the FMA be directed towards abolition of the present malpractice system and a solution to the problem according to the following guidelines:

The State of Florida should enact a Health Compensation Act. Funding should come from all who derive income from the health care system by requiring them to leave a percentage of their earnings in a fund to support the health act. These would include hospitals and employees, drug manufacturers, hospital equipment manufacturers and physicians. Administration, including funds, would be handled by a health compensation or state tax. Awards boards would be made up of local and state representatives for medicine, the legal profession and the public. Awards would be made after identification of patients to be compensated. There would be an appeal mechanism within this system. In the interest of good care, the patients themselves must absorb the consequences of the diagnosis, treatment and complications of their diseases. There are, however, many patients otherwise injured as they go through our system. These patients are entitled to an award.

be it further

RESOLVED, That compensatory guidelines be created from the case histories of the patients that are found in the records of physicians and surgeons, insurance companies and the courts.

A motion was made from the floor that the FMA approve and recommend to the Florida State Legislature that each casualty insurance company in Florida be obliged to issue medical malpractice insurance in association with health or other insurance to be purchased by the residents of Florida.

The motion failed to carry.

Dr. Mullen:

"Your Chairman wishes to thank the members of this Reference Committee, Drs. Jack W. MacDonald, Harold Williamson, Robert J. Brennan and Charles Dunn III, and the members who came to speak before the Committee. Without the efforts, assistance and cooperation of all the above, this report would not have been possible. This Reference Committee especially wishes to thank Miss Cindy Jones, our secretary, for her able assistance and cooperation in the preparation of this report.

"Mr. Speaker, I move the adoption of the report of Reference Committee No. I as a whole as amended."

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. I."

Report of Reference Committee No. II

Miscellaneous Business

The Vice Speaker, Dr. Kahn, assumed the Chair and called for the report of Reference Committee No. II, Miscellaneous Business.

Dr. Joseph P. Hendrix, Chairman, and his committee came forward to present the report of the Reference Committee.

Report of the Board of Governors
Report 76-IM-1
Telephone Directory Specialty Headings

The Reference Committee recommended that the Board of Governors' recommendation to the House of Delegates be amended by inserting the word "BOARDS" before the word "ARE" on line four and the words "SPECIALTY SECTION OF THE" before the word "TELEPHONE" on line six. Dr. Hendrix pointed out that by this action, the House will not change the previously adopted policy that "Physicians' names should be listed alphabetically under the heading of "Physicians and Surgeons, M.D." or whatever similar heading is used by the local telephone company in the classified section of the telephone directory. It is permissible in this general alphabetical listing to follow the physicians' name with the simple statement "Practice is limited to"

A substitute motion was made to change the previous House of Delegates' policy limiting listings under the heading of "Physicians and Surgeons, M.D." allowing the listing to follow the physician's name with the simple statement "Practice is limited to" since any other listing is superfluous.

A motion was made to amend the substitute motion by adding that if a county society wishes, it may allow those members engaged in primary care and who will accept new patients on a walk-in basis be allowed to list under the primary care specialties of Pediatrics, Internal Medicine, Ob-Gyn and Family Practice.

The motion to amend the substitute motion failed to carry.

A motion was made to amend the substitute motion by adding the statement that regional legal doctrines and local custom may allow local county deviation from the foregoing.

The motion to amend the substitute motion failed to carry.

The substitute motion failed to carry.

The question was called and the House voted upon the amendments recommended by the Reference Committee. The amendments carried.

Upon recommendation of the Reference Committee, the Board of Governors' recommendation to the House of Delegates was adopted as amended.

Report of the Board of Governors
Report 76-IM-1
Telephone Directory Specialty Headings

The House of Delegates in 1974 adopted Board of Governors Recommendation #6 which established a statewide policy for physician listings in telephone directories. Rule three states . . . "a physician may list himself under no more than two specialty or subspecialty headings, provided he is Board certified or qualified in, or limits his practice to, the primary specialty, and provided further that the specialty or subspecialty is recognized by the American Medical Association and the Advisory Board for Medical Specialties. Any additions must be approved by the Judicial Council".

At its meeting in April, 1975, that part of the Judicial Council's report entitled "Telephone Directory Listings" was referred by the House of Delegates to the Board of Governors for further indepth study.

At its meeting in August, the Board of Governors reviewed a controversy that had arisen regarding a ruling of the Judicial Council approving a listing for "surgery, facial plastic."

The Board of Governors stayed the opinion of the Judicial Council regarding Telephone Directory Yellow Page Listings—Surgery, Facial Plastic and directed that this matter be referred to the Council on Specialty Medicine for consideration by the Florida Society of Otolaryngology and the Florida Society of Plastic and Reconstructive Surgery. The Board additionally requested the Judicial Council to reconsider its opinion after evaluation of the recommendations of these two specialty groups and report back to the Board.

This matter was considered once again by the Board at its meeting in October 1975.

RECOMMENDATION

The Board of Governors recommends to the House of Delegates that the Florida Medical Association adopt the policy that only those specialties and sub-specialties which have certifying boards and which boards are recognized by the American Medical Association may be used for listings in the specialty section of the telephone directory yellow pages.

Report of the Board of Governors
Report 76-IM-2
Continuing Medical Education

The Reference Committee recommended that the House of Delegates adopt the policy that beginning January 1, 1977 the continuing medical education requirements for retaining membership in the Florida Medical Association may be fulfilled in either one of the following manners:

1. Obtaining the AMA Physician's Recognition Award within 3 years.

2. Completing, over a three-year cycle, 150 hours of continuing medical education credits of which a minimum of 60 hours shall be mandatory hours as defined and described by the Florida Medical Association.

A motion was made to amend the recommendation of the Reference Committee by adding a third item, "Certification by the American Academy of Family Physicians, i.e., 150 hours of approved credit over a three-year period."

The motion to amend the recommendation of the Reference Committee carried.

A motion was made that the date of implementation of the continuing education requirements be established as January 1, 1976.

The motion carried.

The recommendation of the Reference Committee was adopted as amended.

POLICY
Continuing Medical Education

Beginning January 1, 1976, Continuing Medical Education requirements for retaining membership in the Florida Medical Association may be fulfilled in either one of the following manners:

1. **Obtaining the AMA Physician's Recognition Award within three years.**
2. **Completing, over a three-year cycle, 150 hours of continuing medical education credits of which a minimum of 60 hours shall be Mandatory hours as defined and described by the Florida Medical Association.**
3. **Certification by the American Academy of Family Physicians, i.e., 150 hours of approved credit over a 3-year period.**

The Report of the Board of Governors 76-IM-2-Continuing Medical Education was received as information.

Report of the Board of Governors
Report 76-IM-3
Assessment

The Reference Committee recommended that the Board of Governors' recommendation to the House of Delegates be amended by inserting the word **"REGULAR"** before the word **"ACTIVE"** in line two; by substituting $150 for $100 in line three; by inserting the word **"AND"** before the word **"LEGISLATIVE"** on line five; by deleting the words **"TO MEET THE PROFESSIONAL LIABILITY CRISIS"** after the word **"ACTIVITIES"** on line five; and adding another phrase after the word **"ACTIVITIES"** to read: **"FURTHER, THAT ONE THIRD OF THIS $150 SHALL BE RETURNED TO THE COUNTY SOCIETIES THAT HAVE A FORMAL PUBLIC RELATIONS AND LEGISLATIVE PROGRAM FOR USE IN THIS ENDEAVOR."**

A motion was made to divide the recommendation of the Reference Committee into two divisions—the amount of the assessment and the portion remitted to county medical societies.

The motion carried.

A motion was made to amend the recommendation of the Reference Committee changing the amount of the assessment from $150 to $100, wherever it appears in the recommendation.

The motion carried 121 to 83.

The motion was made to consider changing the amount returned to county medical societies from "one-third" to "one-half."

The motion carried.

The motion was made to amend the recommendation of the Reference Committee by deleting "and further, that one-half of this $100 shall be returned to the county societies that have a formal public relations and legislative activities program for use in this endeavor."

The motion to amend the recommendation of the Reference Committee was voted on by written secret ballot and carried 153 to 62.

The recommendation of the Reference Committee was adopted as amended.

A motion was made that these assessed monies shall be billed for and collected by the FMA office, and that included in such billing should be a summary of the report of our public relations consultants as presented to the First House of Delegates.

The motion carried.

The Vice Speaker, Dr. Kahn, advised the House that the By-laws state that all county medical societies will bill and collect all dues and assessments; however, this represents a special assessment, and the By-laws will be waived in order that the FMA office can bill and collect the assessment.

Upon recommendation of the Reference Committee, the Report of the Board of Governors 76-IM-3-Assessment, was adopted as amended.

Report of the Board of Governors
Report 76-IM-3
Assessment

The Board of Governors is keenly aware of the need for an improved public relations program and for an effective legislative program to resolve the professional liability crisis.

RECOMMENDATION

The Board of Governors recommends to the House of Delegates that each regular active dues paying member of the Florida Medical Association for 1976 be assessed $100 and that these funds be specifically earmarked for public relations and legislative activities.

Dr. Hendrix: "Mr. Speaker, your Chairman wishes to thank the members of this Reference Committee, Drs. R. B. Moore, William M. Straight, Clarence M. Gilbert, and John C. Fletcher, and the members who came to speak before the Committee. We also wish to thank our secretary, Ms. Jan Taylor and other members of the FMA staff for their fine assistance given the Committee.

"Mr. Speaker, I move the adoption of the report of Reference Committee No. II as a whole, as amended.

The motion carried.

"Mr. Speaker, this concludes the report of Reference Committee No. II."

The Speaker, Dr. Murray, recognized the President, Vernon B. Astler, who spoke to the House. Dr. Astler thanked the delegates for supporting the assessment, and advised that the Board of Governors would meet immediately following the House of Delegates and would move as expeditiously as possible to authorize negotiations for a public relations contract for statewide representation, and would implement the county public relations programs into the state program to the very best of their ability.

The Speaker announced an Executive Committee meeting and a Board of Governors meeting immediately following the adjournment of the House.

Dr. Murray: "I would like to express to this House my sincere appreciation and admiration for the way the attendance and interest has developed in all the decisions which have been made. I think all of us feel that the FMA can move forward with not only the brains, but the money, the dedication and the power which we have."

Dr. Murray called on Dr. James Cook, Marianna, to give the benediction.

Dr. Cook: "Heavenly Father, now send us safely home. Leave each of us dedicated to our noble profession, and to the implementation of the decisions of this House. Let us by our actions find Thy grace and favor. In Thy name we ask, Amen."

The House of Delegates adjourned at 11:40 a.m.

General Session

The General Session of the Interim Meeting of the House of Delegates of the Florida Medical Association was called to order at 2:15 p.m. on Saturday, January 31, 1976 in the St. Cloud Room of the Orlando Hyatt House, Orlando, Florida, by President Vernon B. Astler, M.D.

Dr. Astler introduced the persons seated at the head table and recognized Congressman Robert H. Michel (R) Illinois, the House Minority Whip and guest speaker for the General Session. Congressman Michel spoke on the topic of health care delivery. He stated that trends in government health policies threaten the future of freely practiced medicine in this country. Congressman Michel stated that he was critical of "the regulatory maze under which physicians are required to practice" and called for an "effective, results-oriented program, with its priorities straight and clearly defined." He discussed the Department of Health, Education and Welfare which now spends $34 billion more a year than the Pentagon, and stated that he deplored the fact that Congress had overridden President Ford's veto of a "budget-busting" health and welfare appropriations bill. Congressman Michel came out strongly against the Health Manpower Bill and the National Health Insurance Bill sponsored by Senator Ted Kennedy. He did state that the people "do want some sort of health care guarantee" and indicated that he would support an affordable measure.

Regarding medical malpractice insurance, Congressman Michel stated that the problem should be handled at the state level, and recommended the so-called Indiana Plan, which imposes liability and premium ceilings with the state paying court-awarded damages in excess of the ceiling.

Congressman Michel received a standing ovation.

Dr. MaCris introduced the members of the Professional Liability Panel: Senator Kenneth Plante (a member of the Senate Commerce Committee). Rep. J. Hyatt Brown (a member of the Governor's Malpractice Liability Commission), Dr. James W. Walker, President, PIMCO, and Dr. James B. Perry, Chairman of the Council on Legislation and Regulations.

Dr. MaCris reminded the General Session that

"Our aim as far as the physicians throughout Florida and throughout the country is concerned, is to seek a more equitable solution to the problem of professional liability insurance."

Senator Plante stated that there is no simple solution to the problem of medical liability and that the doors of communication between the Florida Legislature and the medical profession in the State of Florida are wide open, and the legislators are willing to listen and work with physicians in solving this problem.

Rep. Brown mentioned that he has had the pleasure of serving on the Governor's Malpractice Liability Commission and complimented three physician members of the Commission—Drs. Phil Cotton, William Broussard, and Emanuel Papper—for the outstanding job they have done.

Rep. Brown stated that the keystone to the solution of the medical liability problem is an adequate definition of malpractice which will be constitutional and which includes 3 tests: 1) if the injury is more related to the illness than to the intervention, 2) that the burden of proof falls on the shoulder of the plaintiff to prove that the injury is not within the normal risk, and 3) that the injury occurred outside the area of the consent of the patient.

He stated that the consumer is the ultimate bearer of the cost of medical liability and if the medical profession wants meaningful legislation passed, personal involvement is necessary in Tallahassee and on the local level.

Dr. Walker stated that he envisions 1976 as a year when the medical profession can effectively pass necessary legislation to alleviate the medical liability problem, and that the problem must be solved on the state level.

Dr. Perry stated that the situation faced by the medical profession is prevalent in all walks of life in America. He stated that organized medicine has an obligation to solve the problem of medical liability and an obligation to inform every physician in Florida regarding the problems and the need for their personal involvement. He stated that the rising costs of medical care today are a result of defensive medicine.

A panel discussion was held and various points were discussed concerning arbitration systems, contingency fees, and limits on damages.

Senator Plante and Rep. Brown were asked their opinion as to the most reasonable approach in contacting our legislators to convey to them our points of view—both reaffirmed the philosophy of the key contact physician in the local community.

Dr. MaCris introduced Dr. Edward Annis, Past-President of the AMA.

Dr. Annis said that based on his contacts with business leaders and the public at large throughout the country, they are very knowledgeable of medical matters and medical legislation. "The business community has come to realize that our problem is their problem, as it poses a threat to the independent practice of medicine, to the private practice of medicine and to the overall health care of the community."

He said that most people, most business leaders and most congressmen really believe that medical care is escalating far in excess of their ability to pay, and that unfortunately what has always been recognized as basic strengths in medicine, such as technology and specialization, are now damned as being contributing.

"These are frustrating times for elected leaders, and you are the elected leaders of Florida medicine. We are short of and desperately so in many areas, leadership of the courage to remind us that present resources and present income are insufficient to do the job that must be done.

"We must first convince ourselves, that while the problems are many and diverse, we shall continue to work vigorously and with perseverance toward reasonable solutions. We must convince our colleagues that we their elected representatives are doing our very best to represent their interests. We must convince those adamantly opposed to government intervention that we have common aims and objects which can only be met by unified consensus and a unified course of effort. We must convince the legislators the reasons for and the reasonableness of the position that we take and the requests of them that we make. But most of all we must convince the public, our patients, that ultimately they pay the bill, and it is their health and the health of their loved ones that is in jeopardy."

Dr. Annis reflected that the problems are nationwide and that leadership is alert to these problems and capable of dealing with the problems, but it is up to all of us to provide the means.

Dr. Annis concluded with the quote "Vigorous fighting for what is right is the greatest sport the world affords." (Theodore Roosevelt)

CANDID

PHOTOGRAPHS

FROM

FMA INTERIM

MEETING OF

THE

HOUSE OF DELEGATES

ORLANDO

JANUARY 29-FEBRUARY 1

1976



(Upper left) Reference Committee II: Dr. R. Benjamin Moore, West Palm Be Dr. Clarence M. Gilbert, Orlando; Dr. Joseph P. Hendrix, Chairman, Port St. Ms. Jan Taylor, recorder, Jacksonville; Dr. John C. Fletcher, Tampa; and William M. Straight, Miami. (Below) Reference Committee I: Dr. Charle Dunn, Miami; Dr. Jack W. MacDonald, Tallahassee; Dr. Robert J. Brennan, Lauderdale, Dr. John C. Kruse, Jacksonville; Dr. Sanford A. Mullen, Chairr Jacksonville; Ms. Cindy Jones, recorder, Jacksonville; and Dr. Harold L. Will son, Tampa. (Below) The House of Delegates in session. (Bottom) Dr. Ja W. Walker, Jacksonville; Dr. Vernon B. Astler, Boynton Beach and W. Ha Parham, D.H.A. (Photographs courtesy of Dr. John W. Glotfelty, of Lakeland Dr. Robert E. Windom, of Sarasota).



Upper right) Dr. Robert E. Windom, Sarasota; Dr. Irving M. Essrig, Tampa and Dr. Gerold L. Schiebler, Gainesville; Dr. Burns A. Dobns, Fort Lauderdale and Dr. James T. Cook, Marianna; Dr. Frederick C. Andrews, Mt. Dora, Dr. Joseph C. Von Thron, Cocoa Beach and Dr. William J. Dean, St. Petersburg; Dr. Frank C. Coleman, Tampa, Dr. Jack A. MaCris, St. Petersburg and Dr. Joseph C. Von Thron, Cocoa Beach. (Second row) Dr. Louis C. Murray, Orlando, Dr. Edward W. Stoner, Oviedo and Dr. Donald G. Nikolaus, Dunedin; Dr. Irving M. Essrig, Tampa, Dr. Richard S. Hodes, Tampa and Dr. Thad Moseley, Jacksonville; Dr. Thomas M. Caswall, Bartow and Dr. Millard E. Manry, Lake Wales; Dr. H. Quillian Jones Jr., Fort Myers; Dr. William W. Trice, Tampa and Dr. Thomas E. McKell, Tampa. (Third row) Dr. Rufus K. Broadaway, Miami; Dr. Robert B. Katims, Miami; Dr. Edward R. Annis, Miami and Dr. Jere W. Annis, Lakeland; Dr. Robert B. Katims, Miami and Dr. William F. Hill Jr., Winter Haven; Dr. E. Charlton Prather, Orange Park and Dr. Jerome Benson, Miami Beach; Dr. Andre S. Capi, Fort Lauderdale. (Fourth row) Mr. Roy Pfautch, St. Louis, Mo.; Dr. Ray E. Murphy, Pompano Beach; Dr. J. Lee Dockery, Gainesville; Dr. Jack Q. Cleveland, Coral Gables; Dr. Nicholas H. Kalvin, Naples; Dr. John A. Rush Jr., Jacksonville; Dr. Marvin G. Burdette, Winter Haven; Dr. J. Gerard Converse, Winter Haven. (Fifth row) Dr. James B. Perry, Fort Lauderdale; Dr. Emmett F. Ferguson, Jacksonville; Dr. S. J. Barranco, Winter Haven; Mr. Paul Newman, Diamond Bar, Calif.; Mr. John French, Tallahassee; Dr. Joseph H. Davis, Miami; Dr. Yank Coble, Jacksonville; Dr. Louis E. Cimino, Tampa and Dr. Richard S. Hodes, Tampa. (Bottom row) Dr. William W. Thompson, Fort Walton Beach and Dr. Laurie L. Dozier, Tallahassee; Dr. Joseph Harris, Miami Beach; Dr. Thomas S. Edwards, Jacksonville; Congressman Louis Frey, Orlando, Dr. Vernon B. Astler, Boynton Beach and W. Harold Parham, D.H.A.; Dr. John Parker, Perry; Congressman Robert Michel, Peoria, Ill.; Dr. David C. Lane, Fort Lauderdale and Dr. Jack A. MaCris, St. Petersburg.

Summary of Meeting
FMA Board of Governors
January 18, 1976

The following is a summary of the actions taken by the Board of Governors at its recent meeting, January 18, 1976, in Orlando.

The Board:

AWARDS Selected the recipient for the 1976 A. H. Robins Company Award for outstanding community service by a physician and the Layman's Award, and approved a nomination to the House of Delegates for the Certificate of Merit.

KEY CONTACT PHYSICIANS Selected the National Key Contact Physician assignments for 1976.

HEW MEDICAL PROJECT REVIEW TEAM Nominated twelve FMA members to HEW for appointment to the Medicare Program Review Team for Florida: Burns A. Dobbins, M.D., Thomas E. McKell, M.D., Frank Hodnette, M.D., Ralph C. Aye, M.D., John A. Dyal, M.D., Charles P. Hayes, M.D., Willard E. Manry, M.D., Charles B. Mutter, M.D., Elwin G. Neal, M.D., Abbott Y. Wilcox, Jr., M.D., and Clarence Gilbert, M.D.

SPECIAL COMMITTEES Was advised of the President's appointment of special Committees on the Cost of Medical Care, Nursing Homes, and Sports Injuries.

EDITOR: FMA JOURNAL Approved the President-Elect's selection of Gerold L. Schiebler as Editor of **The Journal of the FMA** for 1976, noting the excellent job Dr. Schiebler has done in the present term.

FMA MEDICAL DISTRICTS Voted to retain for 1976 the current designation of the FMA Medical Districts.

PLI LEGISLATION Adopted and submitted to the Interim Meeting of the House of Delegates the legislative goals for professional liability insurance as outlined in Dr. Astler's statement to the Professional Liability Insurance Commission.

LONG-RANGE PLANNING COMMITTEE Approved appointment of a long-range Malpractice Planning Committee chaired by the President-Elect to study the current tort system and develop a program to change its inequities or abolish it.

CONTINGENCY FEES Reviewed the petition filed by the FMA for modification of the contingency fee proposal filed by the Florida Bar in the Florida State Supreme Court. FMA contends that the amendment suggested by the Bar is much too high to bring about improvements.

WORKMEN'S COMPENSATION INCREASE/ PLANS Was advised that as a result of the petition filed by the FMA for revision of the Medical and Surgical Fee Schedule for Workmen's Compensation the Department of Commerce has announced an across the board increase of 32%. The new schedule, which goes into effect March 1, 1976, contains actual dollar allowances for each procedure rather than relative values with conversion factors. FMA's proposal for use of the 5-digit code system was rejected. The 4-digit code and nomenclature will be continued.

MEDICARE: DCMA Heard a report from Dr. Robert Katims, President, Dade County Medical Association, on his recent conference with Mr. Tierny of the Bureau of Health Insurance in Washington, D.C., concerning problems with Group Health Insurance, the Medicare intermediary for Dade and Monroe counties. It was pointed out that the FMA had no input in the decision of HEW to separate Dade and Monroe counties from the rest of the state.

MEDICAID-PHYSICIANS' SERVICES Directed that a letter be sent to the Governor and Secretary Page expressing strong opposition to the cutback in allowances for physicians' services under Florida's Medicaid Program and dis-

may over mismanagement of the program. The Board further stressed that this cutback will result in further reductions in services available to Medicaid recipients.

MEDICARE PAMPHLET — Approved distribution to all FMA members in the next issue of the FMA Briefs a Medicare informational pamphlet with the suggestion that it be used to inform patients of recent reductions in Medicare benefits.

FMA-PLI-TRUST — Approved procedures to be used by PIMCO for establishment of FMA — FMA-PLI-Trust Committee structure in county medical societies, and authorization for county medical society committee review procedures.

BLUE SHIELD BOARD — Approved nominations to Blue Shield for three physicians' seats and three laymans' seats to fill terms expiring on the Blue Shield Board.

CONGRESSIONAL VISITATIONS — Approved continuation of FMA's Congressional Visitation Program for 1976 with emphasis on regular visits by individual key contact physicians with their assigned congressmen in Washington.

LEGISLATIVE REGIONAL WORKSHOPS — Approved FMA participation in regional workshops for the purpose of educating Florida physicians on their political and governmental responsibilities as well as actions being taken by FMA in the area of professional liability insurance.

DOCTOR.....

Mark Your Calendar

MAY 5-9, 1976
102nd ANNUAL MEETING
FLORIDA MEDICAL ASSOCIATION
DIPLOMAT HOTEL, HOLLYWOOD

Scientific and Educational Exhibits

Convention Hall

May 6-8, 1976

A — "Craniofacial Correction of Severe Facial Deformities" — Mutaz B. Habal, M.D., and Jack Maniscalco, M.D., Gainesville.

B — "Needles for Neurosurgery" — Jack E. Maniscalco, M.D., Gainesville.

C — "Trans-Sphenoidal Hypophysectomy in Metastatic Breast Carcinoma," Glenn Morrison, M.D., Coral Gables.

D-E — "Acute Otitis Media in Children—A Dilemma" — Samuel E. McLinn, M.D., Harrisburg, Pa.

F — "Thyroid Radioassays—A Comparative Study" — F. S. Ashkar, M.D., and A. V. Heal, Ph.D., Miami.

G — "Results of Coronary Revascularization by Autogenous Vein Grafts" — James R. Jude, M.D., Irwin Boruchow, M.D., N. V. R. Iyengar, M.D., and John B. Oak, M.D., Miami.

H — "Office Photography" — John W. Devine, M.D., Miami.

J — "Organization of Perinatology Services in a Community Hospital" — John M. O'Lane, M.D., and Ali Rabbani, M.D., Detroit, Mich.

K — "The Community Hospital Education Program for Residents" — Thornton A. Beckner, M.D., Orlando.

L — "Prevention of Rheumatic Fever and Rheumatic Heart Disease" — Florida Task Force on Rheumatic Fever.

M — "UGI Endoscopy: Diagnostic and Therapeutic Value" — Michael Guber, M.D., Miami.

N — "Voluntary Health Agencies in Florida" — Florida Voluntary Health Association.

O — "Heart Valve Replacement" — James R. Jude, M.D., N. V. R. Iyengar, M.D., Irwin Boruchow, M.D., and John B. Oak, M.D., Miami.

P — "Nurse-Midwifery" — Florida Council on Nurse-Midwifery

Q-R — "Cephradine and Cephalexin Therapy in Children" — Raja Mouallem, M.D., New Orleans, La.

S — "Congenital Defects Surveillance and Referral" — Florida Health Program Office.

T — "Sudden Infant Death Syndrome — Information and Counseling" — Florida Health Program Office.

U — "Applications of Diagnostic Ultrasound to Cardiovascular Disease in the Young" — Pedro L. Ferrer, M.D., Miami.

V-W — "Stigmata of Respiratory Tract Allergies—Usual and Unusual Signs" — Meyer B. Marks, M.D., Miami Beach.

X-Y — "Hypertension Control and Renal Disease Programs in Florida" — Florida Health Program Office.

Z-AA "Monitoring the Woman in Labor—The OB-ICU Experience at NYU-Bellevue" — Bruce K. Young, M.D., and Howard Weinstein, M.D., New York, N.Y.; and Howard M. Hochberg, M.D., and Michael E. D. George, B.S.E.E., Cranbury, N.J.

BB-CC "Transhepatic Portography" — Manuel Viamonte, Jr., M.D., Raul Pereiras, M.D., Edward Russell, M.D., James LePage, M.D., Patrick White, M.D., Duane Hutson, M.D., and Robert Zeppa, M.D. Miami Beach.

DD-EE "Comprehensive Management of Epilepsy" — Samuel Livingston, M.D., Lydia L. Pauli, M.D., Irving Pruce, B.S., Herbert L. Livingston, D.D.S., and Sumio Uematsu, M.D., Baltimore, Md.
Note: Due to an unusually high number of exhibit applications, several good scientific exhibits could not be fit in the Exhibit Hall floor plan. The Committee on Continuing Medical Education is hopeful that additional space can be found so that some of these exhibits can be shown.

More Speakers Added for Annual Meeting Program

Speakers for the "Dialogue" series during the scientific sessions of the 102nd Annual Meeting of the Florida Medical Association have been announced by the Committee on Continuing Medical Education.

Two one-hour segments of "Dialogue" will be presented at the Diplomat Hotel in Hollywood on Thursday afternoon, May 6, and two more the following morning through the courtesy of Pfizer Laboratories and Roerig, Division of Pfizer Pharmaceuticals.

"Dialogue" speakers will include: Sanford Chodosh, M.D., Associate Professor of Medicine, Boston University School of Medicine, Boston, Mass.; T. S. Danowski, M.D., Clinical Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pa.; Joseph N. DiGiacomo, M.D., Associate Professor of Psychiatry, University of Pennsylvania of Pennsylvania Medical School, Philadelphia; and Thomas A. Hoffman, M. D., Assistant Professor of Medicine and Chief of Infectious Diseases, University of Miami School of Medicine, Miami.

The schedule:

Thursday (1:30 to 2:30 p.m.)—"Management of the Diabetic Patient"—Dr. Danowski.

Thursday (3:30 to 4:30 p.m.)—"Appropriate Antimicrobial Therapy"—Dr. Hoffman.

Friday (8:30 to 9:30 a.m.)—"Management of the Depressed Patient with Cardiovascular Disease"—Dr. DiGiacomo.

Friday (9:45 to 10:45 a.m.)—"Treatment of the Asthmatic Patient"—Dr. Chodosh.

At the outset of each hour, the guest speaker will give a five or ten minute overview of his subject. The remainder of the hour is an unstructured program of questions and answers.

Virtually the entire scientific program was published in the February issue of **The Journal.** Sponsoring specialty groups have announced the following additional speakers:

Symposium on Hypertension (Wednesday, May 5, 1:00 to 3:00 p.m.)—In addition to speakers previously announced, William P. Castelli, M.D., Director of Laboratories, National Heart Institute, Heart Disease Epidemiology Study, Framingham, Mass., will speak on "Epidemology of Hypertension."

Section on Chest Medicine (Thursday, May 6, 2:00 to 5:00 p.m.)—There will be a Cardiology Hour at 4:00 p.m. entitled "Combined Coronary and Valvular Surgery: Operative Risks and Long Term Results." The speaker will be Parry B. Larsen, M.D., Attending Surgeon, Miami Heart Institute, Miami Beach.

Symposium on Government Health Planning and Organization (Friday, May 7, 8:30 to 10:45 a.m.)—James A. Alford, M.D., of Tallahassee will speak on "Health Service Areas (HSAs) in Florida." Dr. Alford is Assistant Secretary for Program Planning and Development, Florida Department of Health and Rehabilitative Services.

Section on Dermatology (Saturday, May 8, 8:30 a.m. to 12:30 p.m.)—Guest speaker is Richard Stoughton, M.D., Head of the Division of Dermatology, Scripps Clinic and Research Foundation, La Jolla, Calif. Dr. Stoughton will present two papers: "Recent Advances in Topical Steroids" and "Current Status of Topical Antibiotics in Acne."



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

ound useful in the management of vertigo* associated with
ases affecting the vestibular system.
an relieve nausea and vomiting often associated with vertigo.*
sual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
lso available as Antivert (meclizine HCl) 12.5 mg. scored
ets, for dosage convenience and flexibility.
ntivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for
sea, vomiting and dizziness associated with motion sickness.

SUMMARY OF PRESCRIBING INFORMATION

DICATIONS. Based on a review of this drug by the National Academy of
ences—National Research Council and/or other information, FDA has classified
indications as follows:
ffective: Management of nausea and vomiting and dizziness associated with
tion sickness.
ossibly Effective: Management of vertigo associated with diseases affecting the
tibular system.
inal classification of the less than effective indications requires further
estigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Antivert®/25
(meclizine HCl) 25 mg. Tablets
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FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Announcing the

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The Florida Medical Association, Inc., Board of Governors approved a proposal presented by Jack Nicklaus Leasing Company, Inc., for an automobile leasing plan that was specifically designed for the FMA membership. Your association will sponsor this program because it represents a real service to its members that is more economical and convenient than most people can obtain individually. The program provides full flexibility in securing contracts of your choice. You can lease the make and model you want, along with optional equipment. The automobile is delivered through a local dealer, or dealer of your choice whenever possible. Other benefits include special insurance rates, use of a free loaner car when servicing is necessary under the full-maintenance contract, and security deposits will not be required. A brochure giving full details of this program has been mailed to you.

If you would like immediate information, please call Mr. Carl Shillinger, General Manager, Jack Nicklaus Leasing Company, Inc., at 305/276-3036 (collect).

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Charles K. Donegan, M.D., of St. Petersburg . . . has been appointed Governor-Nominee for Florida of the American College of Physicians.

The appointment was announced by Robert G. Petersdorf, M.D., of Seattle, Wash., President of the ACP. Dr. Donegan succeeds Leighton Cluff, M.D., of Gainesville, Chairman of the Department of Medicine at the University of Florida College of Medicine. He resigned to become Vice President of the Robert Wood Johnson Foundation in New Jersey.

Dr. Donegan has been active in Florida Medical Association affairs for many years. A former Speaker of the FMA House of Delegates, he currently is an alternate delegate to the American Medical Association and chairs the FMA Committee on Relative Value Studies.

George A. Richard, M.D., of Gainesville . . . has been appointed to the American Medical Association's ad hoc Advisory Committee for the Fourth Edition of Current Procedural Terminology (CPT).

Dr. Richard, Professor of Pediatrics and Chief of Pediatric Nephrology at the University of Florida College of Medicine, represents the American Academy of Pediatrics on the panel.

The University of Miami School of Medicine . . . is establishing a new research and treatment center for lung diseases.

The center will be named the "Calvin and Flavia Oak Asthma Research and Treatment Facility," in recognition of a $150,000 gift from the late Calvin Oak, a Miami banker. William J. Harrington, M.D., Chairman of the Department of Medicine, will be in overall charge of the center.

Donald J. Massaro, M.D., presently Professor of Medicine and Director of the Pulmonary Program at George Washington School of Medicine, will direct the facility when it opens in June. In all, a faculty of 10, plus 20 technicians and other support personnel will staff the center.

The Team Physician is a Lady . . . When the Escambia Raiders of Pensacola kick the football to the opposing team, there's a quiet, concerned lady watching from the coach's bench.

An overly concerned mother of one of the players? No, she's Nell Potter, M.D., and the team physician of the Raiders, there on the job to treat injured players who may suffer anything from a sprain to a heat stroke. Dr. Potter, who's been team physician of the Raiders for three years and for another team previously, said that during this time only two serious injuries have resulted. "I'm amazed we get as few injuries as we do because of the way the boys hit," she said.

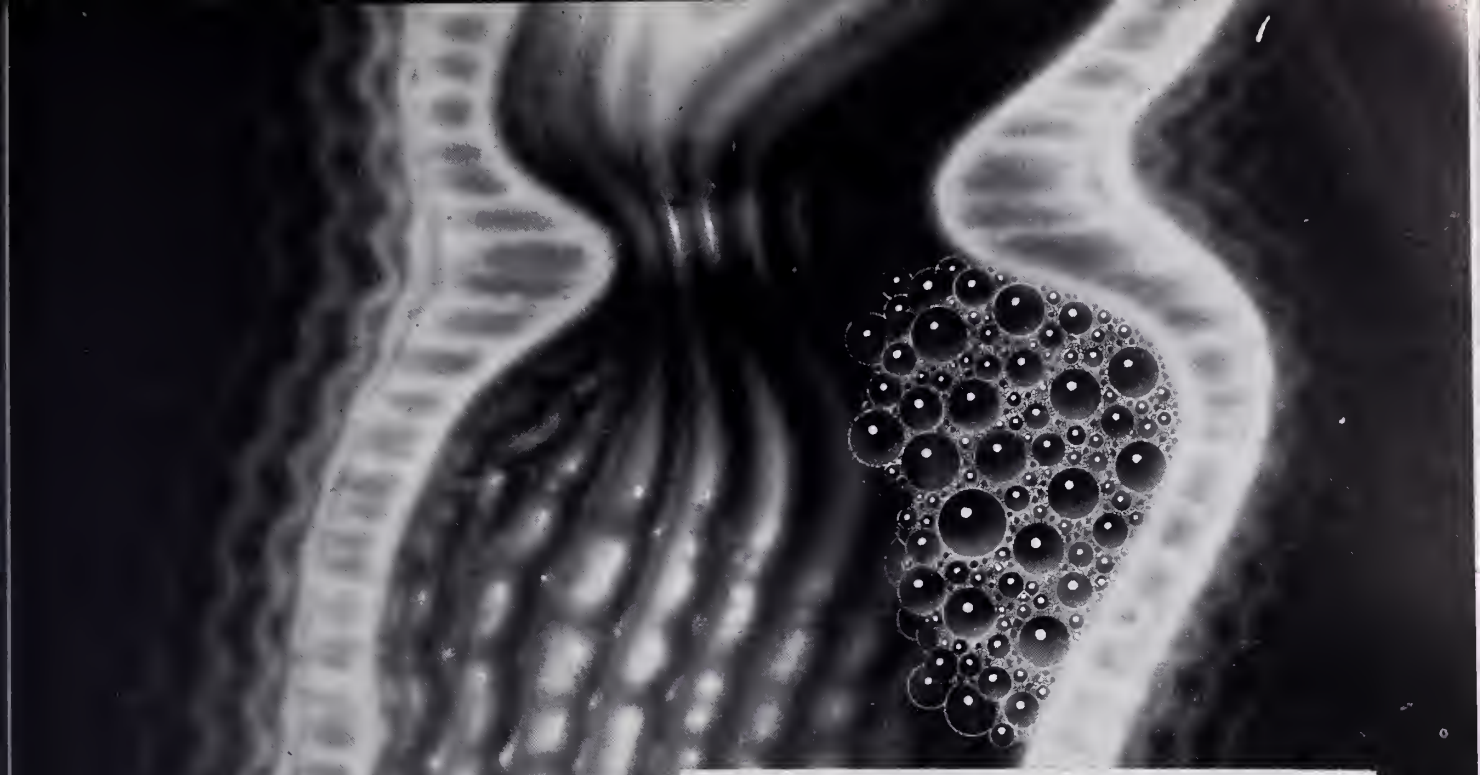
After the game in the dressing room, Dr. Potter keeps her back to the players as much as possible while still carrying out her role as team physician. She treats adolescents and young adults, and has several of the players as her patients.

Her husband, Dr. Jim Potter, is a Pensacola pathologist.

The Escambia County Medical Society began the program of having members serve voluntarily as team physicians for schools, generally located near their offices. The Society also opposed using chiropractors as team physicians for Pensacola area schools.



Dr. Potter examines the arm of a Raider player.



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Not so when you prescribe Sidonna. Sidonna helps release entrapped gas with specially activated simethicone, a nonsystemic antiflatulent, while also helping to relieve spasm with a traditional combination of belladonna alkaloids. And Sidonna provides mild sedation with butabarbital.

Sidonna. The therapeutic partnership approach to functional or organic GI disturbances including spastic colon, irritable bowel syndrome, gastroenteritis, gastritis, peptic ulcer and nervous indigestion.

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Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Tenements of Clay, An anthology of medical biographical essays, edited by Arnold Sorsby. 258 pages. Illustrated. Price $7.95. Charles Scribner's Sons, New York, 1975.

This volume contains the medical biographies of thirteen famous persons and an essay upon the historical implications of porphyria. Each essay is the product of a different author and thus there are different styles but all are pleasantly written. The editor, emeritus research professor of the Royal College of Surgeons, writes a prefatory note for most of the essays and explanatory footnotes which are helpful, especially for the nonmedical reader. Unfortunately, he does not introduce us to the essayist, an omission which this reviewer deplores. This volume is recommended to the historically oriented layman or physician and particularly to those who have a special interest in the lives of: Noah, Job, Henry VIII, William Shakespeare, John Milton, Jonathan Swift, Samuel Johnson, King George III, Jan Austen, Ludwig van Beethoven, Napoleon and Abraham Lincoln.

William M. Straight, M.D.
Miami

Dr. Straight is Historical Editor of the JFMA.

Review of Medical Pharmacology, 4th Edition; by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D., M.D., and Alan Goldfein, M.D. Illustrated. 821 Pages. Price $10.50. Lange Medical Publications, Los Altos, Calif., 1974.

This attractive encyclopedic reference is well printed with legible type. It attempts to foster skeptical attitudes toward drug advertising claims and recommends that the practicing physician occasionally re-examine his prescribing habits. The text may be helpful for medical examinations.

The physician who uses this book may find, as I did, that "decaffeined coffee" may contain as much as one fourth the amount of caffeine in regular coffee and that cola drinks have about 50 mg. caffeine per 12 ozs. in contrast to 100 mg. caffeine per cup of regular coffee.

In all, I found this an interesting, well edited encyclopedic text.

Harry C. Goldberg, M.D.
Palm Beach

Dr. Goldberg is a practicing Dermatologist in Palm Beach.

Medicine and Morality, a Selected Bibliography prepared by Florida Technological University, Orlando, Florida, 1975.

A bibliography prepared by the library staff at Florida Technological University to inform the public about topics discussed in two series of programs entitled "Medicine and Morality." Bibliographies are available on request, without cost as long as the supply lasts. Requests should be brought to the attention of Mr. L. W. Walker, Director of Libraries, Florida Technological University, Box 25000, Orlando, Florida, 32816.

Lifesaving, Rescue and Water Safety by the American National Red Cross. 240 Pages. 240 Illustrations. Price $2.25. Doubleday and Company, Inc., Garden City, N.Y., 1974.

This is the type of book that does not appear frequently on the physician's bookshelf since it is not directly applicable to the practice of medicine; however, members of the medical profession who enjoy water sports or are involved in community safety programs will find this book an excellent resource text on water rescue techniques.

The book is primarily used as a textbook by the American Red Cross for its classes in lifesaving and water safety. These classes are required for professional lifeguards, however, they also appeal to the general public. Consequently, as would be expected, the text is written in clear and easy to understand terminology, each concept is thoroughly explained and fully illustrated. The format for the chapters is in outline form which makes the book well suited for use as a training text. The chapters vary in length and cover general concepts divided into key points. These include Small Craft Safety, Survival Techniques, Ice Rescue, etc.

I was particularly impressed with the chapters on Respiratory Emergencies and First Aid Emergencies. The discussion of mouth to stoma resuscitation for the laryngectomee has been included since laryngectomee's are becoming more common. The reader will also notice there is no mention of artificial airways, this is keeping the text within range of the layman. Another important addition is the topic of spinal injuries resulting from water accidents. The topic includes several illustrations on positioning the injured person, applying cervical traction, and applying a backboard while the patient is still in the water.

The one drawback in this new edition is the introduction of Cardiopulmonary Resuscitation. The authors have inadequately presented the topic with the disclaimer that CPR should only be attempted by qualified persons. However, they continue with a description of CPR technique, giving enough information to lead the layman rescuer to attempt the procedure without giving enough information to lead him to perform the technique properly. I feel this topic should be either deleted or explained and illustrated in detail.

Michael W. Popejoy
Orlando

Mr. Popejoy is a student at Florida Technology University working on a degree in Zoology and will continue for a Doctorate in Neurophysiology at the University of South Florida.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Physician's Handbook by Marcus A. Krupp, M.D.; Norman J. Sweet, M.D.; Ernest Jawetz, M.D.; Edward G. Biglieri, M.D. and Robert L. Roe, M.D 18th Ed. 754 Pages. Price $8.00. Lange Medical Publications, Los Altos, Calif., 1976.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

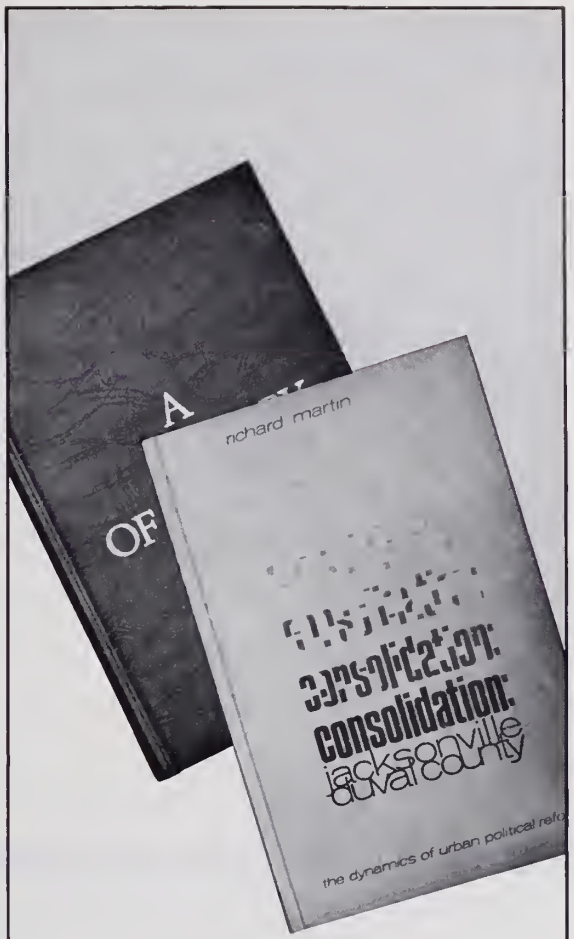
The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.-O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Diet Away Your Stress, Tension, & Anxiety by J. Daniel Palm, Ph.D. 227 Pages. Price $6.95. Garden City, New York, Doubleday & Company, 1976.

Emergency Management of the Critical Patient, Vol. 2, by J. Clifford Findeiss, M.D. 280 Pages. Price $17.95, Stratton Intercontinental Medical Book Corporation, New York, 1975.

Current Medical Diagnosis & Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1,062 Pages. Price $14.00. Lange Medical Publications, Los Altos, California, 1976.



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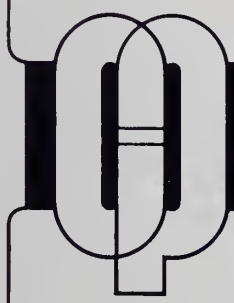
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Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

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Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

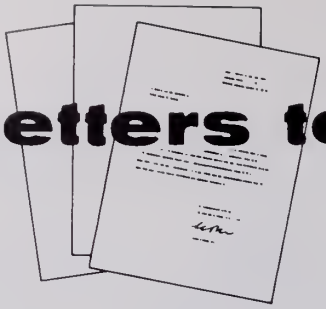
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Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publications should be designated "For Publication."



Letters to the Editor

To the Editor: I am writing this letter in response to the editorial comment by Dr. Fred Q. Vroom concerning my paper entitled "Carotid Endarterectomy in the Treatment of Transient Cerebral Ischemia" which appeared in the November, 1975, issue of the Journal of the Florida Medical Association. It is my contention that certain editorial remarks could be construed as misleading to those Journal readers who are not thoroughly familiar with the subject presented.

In his editorial comments Dr. Vroom stated, "no studies, including the joint study, has shown an impressive difference in patients treated surgically versus medically." The reference given to support this statement (Fields, W. S., et al: Joint Study of Extracranial Arterial Occlusion. V. Progress Report of Prognosis Following Surgery or Nonsurgical Treatment for Transient Cerebral Ischemic Attacks and Cervical Carotid Artery Lesions, JAMA 211:1993, 1970) is also listed in my list of references and actually upholds the opposite conclusion. In this report by the Joint Study, a series of 316 patients with transient cerebral ischemic attacks and no neurological deficit were randomly allocated to surgical or nonsurgical treatment groups in a controlled manner. The results of treatment revealed: 1) "comparison of the percentage of asymptomatic surviving patients in the overall series appears to favor surgery ($P=0.001$)"; 2) "transient attacks were reported in 57 patients (38%) in the surgically treated group during longterm follow-up, as against 79 patients (54.5%) in the nonsurgically treated group"; 3) "occurrence of a new stroke in the follow-up period was 4% in the surgical group and 12.4% in the nonsurgical group."

With regard to the editorial comment that "symptoms (of cerebral ischemia) often are related to the basilar vertebral circulation and hence are not amenable to carotid artery surgery," the following point should be noted. When there is concomitant carotid arteriosclerosis which is both significant and surgically accessible, carotid endarterectomy is indicated as the initial operative procedure since the carotid artery is more easily approached surgically and restoration of flow by this route (depending upon intracranial communications) will frequently obviate the need for further surgery to correct proximal vertebral artery stenosis or subclavian steal syndrome.

Finally, it should be noted that Dr. Vroom's discussion citing the natural history of amaurosis fugax as a carotid syndrome is not entirely accurate since the information provided is based upon a study of 80 unselected patients with amaurosis fugax (Marshall, J. and Swithin, M.: The Natural History of Amaurosis Fugax, Brain 91: 419, 1968); only 27 of the 80 patients in this study had carotid arteriograms performed, and the examination was normal in 10 patients. Interestingly enough, however, the authors of this study concluded that patients with amaurosis fugax should have arteriograms performed and should undergo carotid endarterectomy (when significant lesions are present and surgically accessible) before serious damage occurs.

Daniel B. Nunn, M.D.
Jacksonville

To the Editor: In response to Dr. Nunn's letter of December 11, 1975, I have the following answers:

1) Regarding Progress Report V of the Joint Study, his statement of their conclusions is true. However, if one reads their data for each of the three subcategories or the total series, there is no real difference between those treated medically or surgically. The patients that were treated surgically had a high complication rate, resulting in stroke or death in the immediate postoperative period. On page 998, they stated that they excluded the patients that died or had permanent postoperative deficits on the basis that they had improved their techniques and, therefore, had a lower complication rate in subsequent studies. Unfortunately, they have not proved

that if these patients had lived or had not suffered a permanent deficit that they would have fared better than those treated medically. In order to prove that surgery significantly altered the course of the disease the study would, therefore, have to be repeated. Regarding the differences in frequency of TIA's in the surgical and nonsurgical groups, a similar argument holds. Furthermore, an occasional TIA, particularly if motor function is spared, may not significantly affect the quality of survival. Finally, what is meant by medical therapy is not explained — often medical therapy means no therapy at all.

2) Regarding the importance of a carotid endarterectomy to improve general blood flow to the entire brain, and hence to be of value in basilar artery insufficiency: this is a popular concept, but unproven. In the Joint Study of Extracranial Arterial Occlusion, Part VII, Subclavian Steal — a review of 168 cases (JAMA 222:139, 1972), they pointed out that (a) mortality and morbidity from stroke were exceedingly high in the surgical group, and (b) the patients with subclavian artery disease did not have strokes during the follow-up period whether they were treated medically, surgically, or not at all.

3) Regarding amaurosis fugax, my point was that this may well run a more benign course than the usual TIA from a carotid lesion. It is possible that the small emboli that produce amaurosis fugax are unlikely to produce a significant neurologic deficit since hundreds of attacks can occur without a persistent deficit. Furthermore, two aspirin a day dramatically decrease attacks because of its anticoagulant effect. Whether it prevents a stroke or blindness is still unknown. Whether surgery or aspirin is best is also unknown. To solve this, of course, would require a controlled study.

In summary, I do not mean to be critical of Dr. Nunn's work. It does represent a tremendous amount of work and does prove these techniques can be performed with relative safety. I do mean to point out this is an extremely difficult field, and much is yet to be done. Controlled studies will be required to answer the questions raised and select the best mode of therapy. I personally feel some syndromes, particularly carotid syndromes where there is evidence of ischemia to a large area and hence from large vessel occlusive disease, will be the groups where surgery will best apply. We may find that the best treatment is going to be medical and prophylactic, treating hypertension, cigarette smoking, and obesity long before symptoms are ever present. Unfortunately, once present it may be that vascular disease is so widespread that significant alteration of the natural history of the disease may be impossible.

Fred Q. Vroom, M.D.
Tallahassee

To the Editor: On behalf of the 300,000 members of the National Association for Retarded Citizens, please accept the enclosed Certificate of Appreciation for your use of our Bicentennial Public Education public service advertisement.

With the assistance of the **Journal of the Florida Medical Association,** NARC's goal of ensuring equal legal and human rights for this nation's six million mentally retarded individuals is being garnered through public understanding. We have received requests for information as the result of your publishing our materials.

Thank you for your cooperation with this project.

Peg Barry
Assistant Director, Public Information
National Association for Retarded Citizens
Arlington, Texas

ERRATA: January 1976 Issue

"Gene Determinants and Their Controls," by Charles C. Dugan, M.D.

Abstract: line 12—6th lymphocyte chromosome in humans, 17th lymphocyte chromosome in rats.

Line 54—LD-7a (DW2) which shows a strong linkage disequilibrium is found in 60% to 70% of multiple sclerosis patients.

Line 60—severe disease state occurs usually in LD-7a (DW2).

Line 72—Iceland more frequent multiple sclerosis than Minnesota.

Line 98—W27 is consistently found in 85% of patients with rheumatoid arthritis.

The list of contributors to the special Issue on Dermatology of The Journal in January 1976 appeared on page 157 in February. Another contributor, Ethicon, Inc. of Somerville, N.J. was received too late to be included.

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Product Problem Reporting Program Expanded

Problems related to medical devices, diagnostics, drugs or equipment can now be reported through expansion of the national Laboratory and Medical Product Problems Reporting Program. The United States Pharmacopeia today reported that the College of American Pathologists, the American Association of Clinical Chemists, the American Association for Respiratory Therapy, the American Association of I.V. Therapists, and the International Association of Hospital Central Service Management have agreed to participate in the Medical and Laboratory Problems Reporting Program. It is expected that other associations will join in this effort to provide a quick, easy method for the practitioner to make known to officials in the compendia, industry and government his concerns about the products he uses, thereby leading to product improvements and ultimately to the benefit of the public health.

The Medical and Laboratory Product Problems Reporting Programs are modeled after the successful Drug Product Defect Reporting Program initiated in 1971 which has thus far generated 17,000 reports from pharmacists. Both programs are coordinated by the USP under contract with the Food and Drug Administration. Joseph G. Valentino is Project Director for both programs.

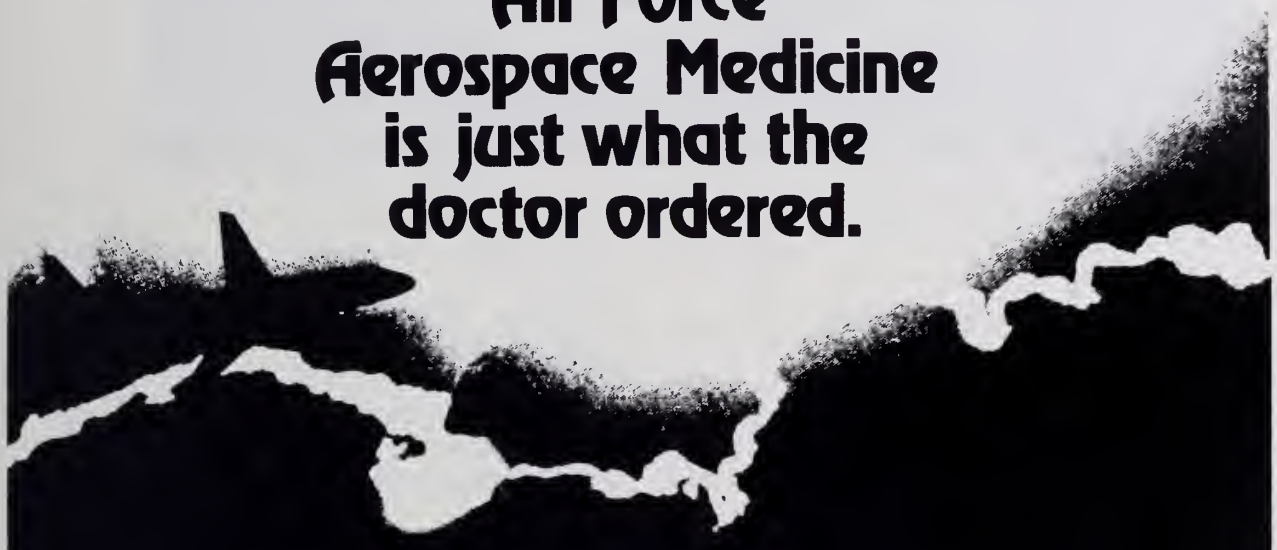
Mailouts of report forms are made periodically to members of participating associations and reports received through the systems are reviewed immediately by USP Staff and forwarded daily to the FDA and the manufacturer. Health hazards as well as significant suggestions for product improvement have been identified by these systems.

Expansion of the Medical Product Problem Reporting Program to these areas of the health care field will be completed during the coming year. Cooperation received from the participating organizations has been enthusiastic. The American Society of Hospital Pharmacists has asked hospital pharmacists to explain the Laboratory Product Problem Reporting Program to appropriate hospital personnel and to encourage their participation.

Further information concerning these programs can be obtained by writing to the United States Pharmacopeia, 12601 Twinbrook Parkway, Rockville, MD 20852.

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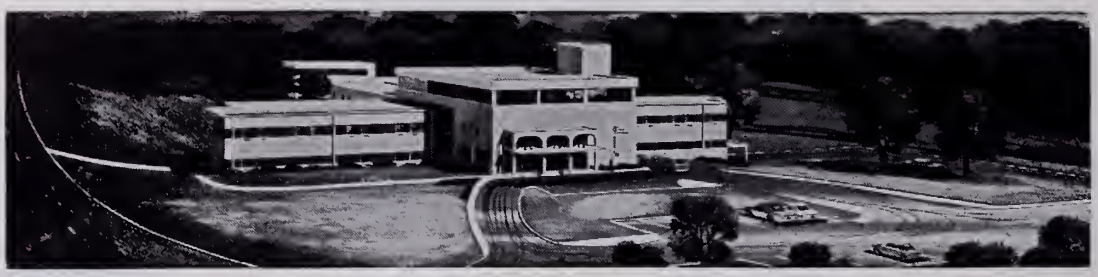
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Others Are Saying

Determining The Right to Die— A Physician's Responsibility

If you were Karen Quinlan's physician, what decisions would you make regarding her care and management? If all HCMA members were to answer this question honestly, I wonder if there would be an overwhelming majority of responses in one direction or the other? Perhaps not. Yet, in effect, by his decision in the Quinlan case, Judge Muir is asking us as physicians the same question. The Judge placed the responsibility of determining the patient's "right to die" back in the hands of the physician. That is where it rightfully belongs. Whether we like it or not, and whether the issue involves social, moral, ethical and even religious connotations, it is the physician who must bear the responsibility.

Daily, physicians are facing decisions regarding whether or not to take steps to terminate treatment in hopeless cases. Most of this is done quietly and usually with the mutual agreement of the patient, the family and the physician. In most cases, the decision —though never easy—is a less difficult one to make. We know, for example, that anencephalic infants live only a few months with the best of care. Withdrawing extraordinary medical efforts allows the disease or condition to cause death in such cases. In a recent survey of 660 internists, 43% said that they would administer increasing doses of narcotics to their terminal cancer patients in pain, knowing full well that in addition to easing the pain, the drug could eventually cause fatal respiratory arrest. Another study showed that 80% of the physicians in the group studied had omitted treatment which would have prolonged the life unnecessarily of certain patients. Most doctors frowned on "actively" bringing about death through the use of drugs. "Passively" allowing death to occur not only by not initiating extraordinary measures, but also through less extraordinary measures (not watching electrolyte balances closely, delaying the administration of appropriate antibiotics, etc.) is more acceptable to physicians and to the rest of society.

Most of us can remember when a patient was dead when his heart stopped beating, and some of us can remember when "extraordinary medical measures" consisted of an injection of Adrenalin. But, with the advances in medical technology, respirators, heart/lung machines and organ transplants, patients who would have died can be kept alive, at least technically, for weeks, months, and even years. One physician stated, "Technology has advanced so, that no one really has to die, so we have to make a choice." In 1968, the Harvard Criteria were established. This eased the ethical problems somewhat. The Harvard guidelines, in general, state that a person is dead if he shows absence of brain waves on the EEG for 24 hours, together with lack of spontaneous breathing, fixed and dilated pupils, and no response to external stimuli. These criteria were established to enable surgeons to remove organs for transplant while the donor's heart was still beating.

But, what are the real issues that Judge Muir and society are asking us to address ourselves? Advances in medical technology only bring the question back to physicians again and again—louder and louder each time. The above standards and guidelines of brain death, anencephalic infants, etc. don't apply to cases like that of Karen Quinlan where neurological signs are present. The real issue to which Judge Muir, and indeed society, are asking us to address ourselves is not whether the patient is dead, but should the patient have the "right to die with dignity" if there is no prospect of a meaningful life. This is the crux of the matter, and the difficult part. Who decides whether or not there is a prospect of a meaningful life, and for that matter, what is a meaningful life? Where do we draw the line? We, as physicians, do not want anyone to legislate medical

procedures. What guidelines can we set without risking euthanasia, or the extreme of "passively" allowing the diseases to bring about death in the ill child, who also happens to be mentally retarded, for example?

Intensive care units, with modern medical technology, could conceivably be filled with patients like Karen Quinlan, or patients with chronic pulmonary diseases being kept alive by machines, among others. In Columbia Presbyterian Hospital, forty to fifty in the 1,600 bed hospital on any given day are having their life prolonged artificially in the intensive care unit. Does the young patient with the chance of recovery, but in need of life support, who was admitted to the hospital after an automobile accident have priority for the use of the respirator occupied by an elderly, chronically ill patient? Is extraordinary treatment for the 80-year-old the same as extraordinary treatment for the 25-year-old? Many more related questions could be raised—but we cannot escape the reality that the physician has the responsibility to set the guidelines for the profession and for the rest of society.

One study at Columbia Presbyterian Hospital showed that most patients treated by extraordinary measures in their intensive care unit were dead within a year from the disease for which they were being treated. The cost is high: $500 per day at Columbia Presbyterian Hospital for a patient in a coma using a respirator. We can't put the responsibility off indefinitely. We need to ask ourselves, in certain cases, "What are we trying to prove? That we have a reverence for life because we will go to incredible means to keep a body functioning?" We should, as physicians, try to prolong useful, pleasurable life, not prolong misery.

It is not only medical technology and its advances which have made the issue of whether or not to prolong life through extraordinary means a more crucial issue recently. The threat of malpractice, distrust of doctor, distrust of family, also have helped to set the stage. Many doctors will leave no medical treatment undone these days, for fear of lawsuit. In a case such as Karen Quinlan's, the doctor must follow his conscience and the wishes of the family, but at his own risk. There are no legal safeguards.

Recently, some solutions have been proposed. Among them is the concept of the "living will" which is signed by the patient, witnessed and addressed to anyone involved in the patient's care. In effect, such a will states that should a situation arise in which there is no reasonable expectation of recovery from mental, or physical disability, the person requests that he be allowed to die by the disease or condition and not be kept alive by artificial means or heroic measures. Dr. Milton Heifetz, a California neurosurgeon, wrote an informative book entitled THE RIGHT TO DIE which deals with the right of the individual to command the movements of his doctors under dire circumstances. He describes "a directive to my physician" written by the patient, who is competent, stating that the physician should cease and refrain from any medical or surgical treatment which would prolong his life if, (1) the patient is in an unconscious state from which he cannot recover, (2) remain unconscious for more than six months, and (3) mental incompetence which is irreversible. These solutions involve forethought by the competent patient, and none are legally binding as of now. It would help if they were made legally binding. What about the patient who is in a coma and does not have "a living will," or, "a directive to his physician"? Florida has no brain death legislation which would allow cessation of extraordinary efforts when the patient is clinically dead. That would help, to a degree, in the decision that the physician must make regarding the "right to die." It has been suggested by a recent Tampa Tribune editorial that "Florida can instruct that death with dignity provisions go into effect when a person is declared terminally ill or injured, by two physicians and with the consent of the patient, or a living will, or two members of the immediate family." Terminal death could be defined legally as an illness or injury that would result in natural expiration of life, regardless of use or discontinuance of medical treatment to sustain life indefinitely.

Whether or not these solutions would be acceptable to most physicians remains to be seen. Surely, as we focus on the issue more and more, new solutions will be found. I do not personally believe that the issue was never meant to be resolved, as many say. In whatever way it is resolved, we must differentiate "euthanasia" which is an act to end life, from "death with dignity" which is allowing death to occur. As physicians, we must push for legislation which gives the patient and his doctor a choice and alternative. We do not want legislation to dictate medical procedure. In the final analysis, whatever solution is acceptable to physicians and the rest of society, the traditional relationship between the physician, the family and the patient must prevail.

Joseph F. Lupo, M.D.
Tampa

Reprinted from The Bulletin, Hillsborough County Medical Association, January 1976.

National Health Service

Great Britain instituted National Health Service in the late 1940's. In Great Britain today:

1. 80% of tax monies allocated towards the National Health Service is for administrative and related costs, not for patient care!
2. National Health is the single largest item in the National Budget—greater than National Defense.
3. A survey in 1960 showed that hospital beds there averaged 50 years old.
4. Quality of health care in Britain has steadily declined since National Health was instituted, due largely to overworked and underpaid doctors, as a result:
5. Professional men are leaving Britain in droves.
6. Annual increase in National Health costs are astronomical.
7. 1975 budget increases were insisted upon by National Health which would otherwise go bankrupt. Prime Minister Wilson said he didn't have the money and refused.
8. Foreigners flock to Britain for "free" medical and dental care.
9. Great Britain has the worst dental health of any nation in the world, i.e., fewer teeth per capita than anywhere.
10. It is common practice in Britain to make a gift of money on a person's 21st birthday to be spent on false teeth made privately rather than "free" national health dentures.
11. There is no money left for medical research. What little research is going on is being funded largely by American Foundations!

I don't have to tell you about the cost increases and abuses which have already occurred in our fledgling Medicare program.

WHEN IN HELL ARE YOU LEGISLATORS GOING TO WAKE UP AND STOP TRYING TO FLUSH US DOWN THE SAME DRAIN BEHIND BRITAIN, SCANDINAVIA AND THE REST OF THE "FREE" HEALTH CARE COUNTRIES?

Make Health Insurance mandatory, get government out and turn it over to private insurance enterprise—they'll make it work and make a profit. If they don't—better they go bankrupt than the whole country. . . .DON'T YOU THINK SO, MR. LEGISLATOR? I am worried!

Gorm P. Hansen, D.D.S.
Fort Lauderdale

Reprinted from The Record, Broward County Medical Association, November 1975.

Very Real Peer Review

The action of the insurance industry of this country has perhaps unwittingly done more to activate peer review in our profession than any other recent event. Due to the failure of any company to willingly underwrite professional liability insurance in this state, the FMA has been forced to form its own PLI Trust to offer coverage to its members.

For some time we have espoused the peer review philosophy, but without our total commitment to action. The government is attempting to force peer review by law, but again without total commitment. But we are now facing a very real peer review that involves the PLI Trust and this must involve our total commitment.

Our Insurance Review Committee (which is being restructured into subcommittees representing the various facets of our profession) is meeting the agonizing challenge of evaluating all of us in regard to our PLI applications.

The FMA plan would probably have been less thought-provoking had the term "insurance" been used. However, when the term "trust" is used, it requires that we, through our committees, evaluate each of us in the light of the trust that the total group can place on our individual ability and quality of care. For **trust** is indeed the key word.

The committee members must decide on each applicant if that individual's professional competence warrants placing our pooled economic resources at the applicant's disposal based on any given professional action by the applicant. The decisions of the committee involve all our necks, not only those of the committee members.

When the committee calls on any of us to help them evaluate an applicant, we should respond with our best effort in an objective evaluation of the applicant's professional actions, and try to minimize our subjective "nice guy" or "don't like him" type of response.

Some of us will probably have our applications questioned. If this does occur, we must realize that any action has been taken without malice and we should attempt to see ourselves through the eyes of our peers.

Ralph M. Stephan, M.D.
Tampa

Reprinted from The Pesident's Page, The Bulletin, Hillsborough County Medical Association, November 1975.

Woman's Auxiliary



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Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.).
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
4. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 21, 1976.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 4:00 p.m. Wednesday, May 5. Shipped entries will be refused.
8. All entries must remain on exhibition until 3:00 p.m., Saturday, May 8. They MUST be picked up between 3:00 and 4:00 p.m., Saturday.
9. We will not be responsible for entries not picked up by 4:00 p.m., Saturday, May 8.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to the St. Augustine Medical Museum.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $_____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

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City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

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Size: _____(H) X _____(W) To be hung on wall.

() B. Graphics. Include pen and ink, charcoal, photography, etc.

Size: _____(H) X _____(W)

() C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

Size: _____(L) X _____(D) X _____(H)

() I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award," given by the Journal of the Florida Medical Association, will be used on the cover of a future issue of the FMA Journal.

A registration fee of $10 will be charged for each entry. Make checks payable to:

WA-FMA ART SHOW
c/o Mrs. William F. Hogan
2861 N. E. 29th Street
Fort Lauderdale, Florida 33306

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 21, 1976

Judging will take place beginning at 10:00 a.m. on Thursday, May 6.

Classified Ads

physicians wanted

FAMILY PRACTITIONERS

MIAMI, FLORIDA: G.P. — Seven man multi-specialty, fee-for-service group is seeking a G.P. to join the group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

FAMILY PRACTITIONERS: Young family physician with a growing, dynamic practice, seeking a board eligible or certified associate for excellent employment contract leading to early full partnership. Presently involved in constructing an ultramodern facility where two men can practice quality family medicine in lovely Altamonte Springs, Florida. Send curriculum vitae to Benjamin G. Newman, M.D., F.A.A.F.P., 201 Maitland Avenue, Altamonte Springs, Florida 32701.

ASSOCIATE FOR FULL FAMILY PRACTICE in Orlando with ABFP physician. **Outstanding** opportunity, good patients, excellent hospitals, good hours and call system. Opening available anytime. Florida license required. Send complete resume and requirements. Write C-713, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED: Part-time family physician in retirement community. Minimal, if any, evening or weekend work. Ideal situation. Please write or call L. C. Taylor, M.D., 1145 Lakeland Hills Blvd., Lakeland, Florida 33801. Phone: (813) 682-4913.

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INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

MIAMI, FLORIDA AREA: Multispecialty group fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

SURGERY, GENERAL: Orlando, Orange County, east-central. American trained, board certified general surgeon sought for purchase of established practice in general surgery and Gyn. Immediate occupancy. Contact Alex P. Maybarduk, M.D., 710 East Colonial Drive, Orlando, Florida 32803. Phone (305) 293-9150.

ASSOCIATE WANTED: Established Obstetrician-Gynecologist in central Florida wants associate. Salary, leading to partnership. Reply to C-706, P.O. Box 2411, Jacksonville, Florida 32203.

OUR PRESENT DEPARTMENT OF PSYCHIATRY is a three man department. We wish to double the size of this over the next three to four years. All candidates must be Board eligible. General psychiatrists or someone with subspecialty interests would be acceptable. Our department is a member of a multi-specialty group located in Pensacola, Florida. Inquiries should be sent to W. M. C. Wilhoit, M.D., Chairman, Department of Psychiatry, The Medical Center Clinic, 1750 N. Palafax St., Pensacola, Florida 32501.

INTERNIST NEEDED: Board certified or board eligible with special interest in cardiology. New 180-bed rural community hospital in central Florida with 10-bed coronary care unit and no Internist. Will build, equip and lease new office OR salary and fringe benefits available as employee of existing PA composed of four family physicians practicing quality medicine. Starting salary range $50,000-$60,000. Write C-707, P.O. Box 2411, Jacksonville, Florida 32203.

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ADDITIONAL PHYSICIANS URGENTLY NEEDED in rapidly growing Gulf Coast area. Most needed are orthopedist, pediatrician and ENT. Excellent private practice opportunity. Rural. Drawing area 40,000. 200-bed excellently equipped hospital. Excellent schools. One and one half hours from medical schools and metropolitan areas. Office space available. Send curriculum vitae to C-708, P.O. Box 2411, Jacksonville, Florida 32203.

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FLORIDA — LAKELAND: Attractive opportunity. Full time emergency department physicians. 900-bed hospital, receives 40,000 annual E. D. visits. Competitive salary with opportunity of profit sharing after one year. Excellent family area within easy reach of unexcelled recreational opportunities. Contact: Paul Stein, M.D., Lakeland General Hospital, Lakeland, Florida 33801. Phone: (813) 686-4913.

PSYCHIATRIST/G. P. PHYSICIAN — Openings are anticipated from time to time in well established Community Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse, Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume', should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

POEMS WANTED: The Florida Society of Poets is compiling a book of poems. If you have written a poem and would like our selection committee to consider it for publication, send your poem and a self-addressed stamped envelope to: The Florida Society of Poets, P.O. Box 1976, Riverview, Florida 33569.

JOB OPPORTUNITY: Director of Health Department (MD & MPA) Prefer emergency medical background. Salary $30,000-$40,000. Resume cannot be kept confidential. Reply before March 1, 1976, to: E. A. Kuhn, Asst. County Administrator, Broward County Courthouse, 201 S. E. 6th Street, Fort Lauderdale, Florida 33301. We are an equal opportunity employer M/F.

WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital 150 beds. Forty hour week. Benefits include four weeks vacation and one week for medical meetings. Starting salary $40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: Jack Geeslin, M.D., Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-3128.

FULL-TIME ER PHYSICIAN—For modern, expanding, fully-accredited 467-bed regional medical center with low malpractice insurance rates, salary and fringes negotiable, progressive staff with specialty back up. Excellent schools, college facilities, cultural activities, recreational activities. Contact Dan S. Wilford, Administrator, North Mississippi Medical Center, 830 South Gloster Street, Tupelo, Mississippi 38801. Phone: (601) 842-3632.

SEEKING PHYSICIANS to relocate Marianna, Florida, trade area of 40,000 people. Recent professionals study indicated the immediate need for 7 physicians to supplement the 6 already here. Financial and business assistance available to qualified physicians. Contact Elwin O'Steen. Phone: (904) 482-4011.

FLORIDA MULTISPECIALTY CLINIC NEEDS PHYSICIANS. 90 minutes from two major university medical centers. New 220-bed hospital with second new hospital under construction. Group practice, fee for service or guaranteed salary. New clinic with x-ray and lab. The Chessick Clinic, 101 Seminole Avenue, Inverness, Florida 32650. Phone: (904) 726-9180.

CAREER ERP POSITION AVAILABLE with established group in large metropolitan medical center in Northeast Florida. Full specialty backup. Florida license required. Liberal salary with desirable fringes. Write C-714, P.O. Box 2411, Jacksonville, Florida 32203.

IS YOUR COLLECTION RATE LESS THAN 85%? Does your office personnel alienate your patients when asking for payment of professional fees? Increase the efficiency of your office—collect more of the money you have earned—easily. Efficiency Enterprises, P. O. Box 1625, Ft. Myers, Florida 33902. Attn: Ms. E. Knox.

Situations Wanted

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UROLOGIST, age 36, board certified, excellent academic background and extensive experience in oncologic surgery, seeks solo, association, or group practice leading to partnership. Write C-718, P.O. Box 2411, Jacksonville, Florida 32203.

CARDIOLOGIST, ABIM, trained in catheterization and noninvasive including ECHO, treadmill wants group or hospital practice with cath. facilities. Available July 1976. Contact J. Rana, M.D., 1134 North 117th Street, Wauwatosa, Wisconsin 53226.

AMERICAN BOARD OF INTERNAL MEDICINE CERTIFIED INTERNIST, age 30, with one year of subspecialty training in cardiology desires practice opportunity in Florida. Available July 1, 1976. If interested call (212) 831-7199 or write Dr. Weisburst, 1601 Third Avenue, New York, N. Y. 10028.

UROLOGIST, age 35 years, married, board eligible, university trained, passed FLEX, extensive surgical experience. Seeks solo, group practice or association leading to partnership. Available July 1976, but would like to finalize it before April 1976. Write C-721, P.O. Box 2411, Jacksonville, Florida 32203.

MATURE, BOARD CERTIFIED, FLORIDA LICENSED, RADIOLOGIST seeks opportunity in routine diagnostic radiology in hospital, private office setting, or combination. Availability negotiable. Write C-719, P.O. Box 2411, Jacksonville, Florida 32203.

NEONATOLOGIST, Florida licensed, interested in level 2 perinatal center or hospital-based position with strong emphasis on the neonatal unit. Experienced in clinical care and teaching. Available July 1976. Write C-720, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: Recently licensed physician seeks position with another General Practitioner in Dade County. Recently completed internship in internal medicine. Write to Steven L. Israel, M.D., 8870 Fontainebleau Blvd., Apt. 410, Miami, Florida 33172. Phone (305) 552-6670.

PATHOLOGIST, 39, married, board certified in anatomic and clinical pathology, 6 years experience in large community hospital, seeks position of associate or director available July, 1975, national boards, Florida licensed. Write C-716, P.O. Box 2411, Jacksonville, Florida 32203.

HOSAIN DAEE, M.D., board eligible OB/GYN with Florida license seeking group practice. Available July 1, 1976. Call: (518) 445-5013 or Dept. OB/GYN, Albany Medical Center Hospital, Albany, New York 12208.

PHYSICIAN'S ASSISTANT is available immediately to work with internist or family practitioner in office or hospital setting. Has BA degree, graduate of two year approved AMA type A program. Prefer Miami area. CV upon request. Write C-717, P.O. Box 2411, Jacksonville, Florida 32203.

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FOR SALE: (1) Pelton Steam autoclave. (2) Burdick Microwave diathermy unit. (3) Burdick Muscle stimulator. (4) One articulated skeleton. (5) Picker x-ray unit, 300 ma, 125 pkv. 90/15 tilt table, fluoroscope, spot film device, floor to ceiling tube stand with electromagnetic locks, videx collimator, electronic bucky, 12/1 grid. Contact Alex Trombly, (813) 253-0481, 8:00 - 5:00.

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OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

PEMBROKE PINES — WEST OF HOLLYWOOD — Fort Lauderdale. Superb opportunity. New medical building. 30,000 sq. ft., adjacent new 300 bed general hospital; office layout to suit needs of all specialties. Contact Dr. Harvey Peretz, 4801 Hollywood Blvd., Hollywood, Florida 33021. Phone: (305) 621-3792.

ST. PETERSBURG: Pasadena Medical-Dental Building, 419 Pasadena Avenue South. New deluxe office building. Just minutes from Palms of Pasadena and St. Petersburg General Hospitals. Custom designed for your needs. For complete information call Gerald F. Dalrymple (813) 866-2474.

LAKELAND, FLORIDA: FOR SALE, 6% down. Air-conditioned office for three physicians. Main street, 168 sq. ft., double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

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FOR RENT, WEST PALM BEACH: Unusually good central location on South Flagler Drive. New, one story building. Parking. Call (305) 655-8620.

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Advertisers

Air Force
Opportunities 241

Asheville School
Service 242

Atlantic Investment Advisers
Service 240

Auto Leasing
Service 231

Ayerst Laboratories
Beminal 212

Burroughs Wellcome Co.
Empirin 181

Convention Press 235, 237

Geriatric Pharmaceutical Corp.
Cevi-Bid 189

Hill Crest Hospital
Service 242

Lederle Laboratories
Incremin 211

Eli Lilly & Co.
Kefzol 190

Mead Johnson
Vasodilan 185

Medfield Center
Service 178

Pharmaceutical Manufacturers Assn.
Institutional 182, 183

Reed and Carnrick
Sidonna 233

Roche Laboratories
Librium Third and Back Covers
Valium 174, 175

Roerig, A Division of Pfizer Pharmaceuticals
Antiminth 178, 179
Antivert 230a

Smith, Kline & French
Dyazide 230a

Westwood Pharmaceuticals, Inc.
PreSUN 186

Willingway Hospital
Service 236

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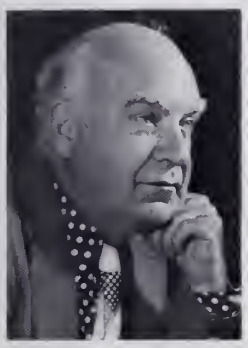
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vol 63 #4

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Dr. Lane



Dr. Hodes



Dr. Lehman



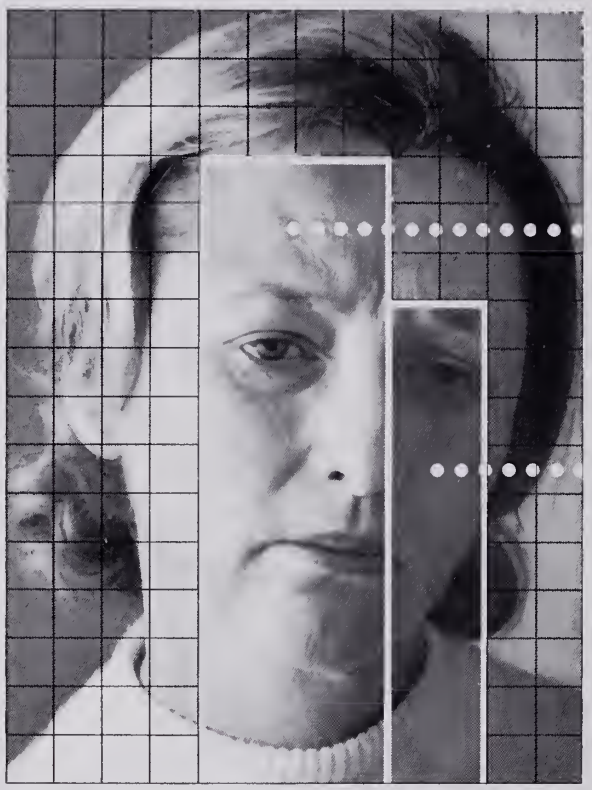
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Predominant psychoneurotic anxiety

Associated depressive symptoms

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Scientific Articles

Early Strategies in Treatment of the Depressed Patient
Jose J. Llinas, M.D. ... **271**
A New Era for Tuberculosis
Allan L. Goldman, M.D. ... **278**
Seminar on Tuberculosis and the Community Hospital
Joel L. Nitzkin, M.D. and John Q. Cleveland Jr., M.D. **282**

Special Article

A Look at the "Baker Act"
Philip B. Phillips, M.D. and Roswitha B. Fischer, M.A. ... **287**

Case Report

Sneeze Neuropathy
Allan Herskowitz, M.D., Paul Fass, M.D. and Marshall Abel, M.D. ... **291**

Sections

President's Page
Doctors as Fiscal Agents
Vernon B. Astler, M.D. ... 257
Books Received ... 305
Book Reviews ... 304
Commentary
PLI Up-Date ... 298
Dean's Page
Standards of Quality in Medicine
Donn L. Smith, M.D. ... 264
Editorial
The Physician Legislator ... 293
Legislative News
April Showers
John C. Kruse, M.D. ... 260
Letters to the Editor ... 303
Medical News Around the State ... 307
Organization
They Will Be There ... 297
Others Are Saying
The Medical Commons
Roy H. Behnke, M.D. ... 300
Man, The Vanishing Species
H. K. Moore, M.D. ... 301
American Medicine in 1776
Frank Chappell ... 302
Woman's Auxiliary
Tenth Annual Benefit Art Show Application ... 308
Program for Woman's Auxiliary Annual Meeting ... 309
AMA-ERF Donation Form ... 310
European Medical Seminar ... 295

Information

Classified Advertising ... 315
FMA Officers and Council Chairmen ... 318
Information for Authors ... 305
Index to Advertisers ... 318
Meetings ... 312
Statement of Ownership, Management and Circulation ... 314

April Cover—The cover highlights Florida's physician legislators, Senator David C. Lane and Representatives Richard S. Hodes, David J. Lehman Jr. and Walter W. Sackett Jr. and the artist's conception of the remodeled Tallahassee FMA headquarters.

About the Cover

(FMA Capital Office Building)

This month's cover includes an artist's rendition of the new FMA Capital Office Building. A former drug store immediately behind the Hilton Hotel, facing the Capitol in downtown Tallahassee was purchased and is currently being renovated for your Association's Capital Office. There are approximately 3,000 square feet in the building. This building and the renovation are being paid for from a liquidation distribution of the FMA's interest in Harlan–Med Insurance Agency and not from the reserves of the Association.

Your FMA Capital Office Staff, headed by Mr. Donald S. Fraser, Public Affairs Director, and Mr. George S. Palmer, Jr., Office Manager, has been enlarged for this session of the Legislature through the retention of former Sen. Mallory Horne, Immediate Past-President of the Senate; John French, Esq., former Staff Director of the House Elections Committee and Executive Director of the Democratic Party; and Nancy Moreau, Legislative Analyst. Other consultants will be added as deemed necessary and advisable for the implementation of our legislative program this year.



President's Page

Doctors as Fiscal Agents

Rarely in today's marketplace does one individual authorize another, as his agent, to spend whatever funds are necessary in his behalf. Because of our heritage as physicians, and the patient-physician relationship, this is precisely what occurs daily in the field of health delivery. If this trust is to endure in our consumer-oriented society, we must act in a fiscally responsible manner as our patient's agent. From an economic viewpoint, the single most important page on the patient's chart is the physician order sheet.

Today more than two billion medical laboratory tests are performed each year in the United States at an annual cost exceeding $6 billion. These tests are projected to increase to six billion per year by 1980 at an estimated annual cost of $20 billion. Certain tests are obvious reduplications—a BUN ($7.05) or a bilirubin ($12.95) when a chemistry profile is working. Other studies are invalid from the outset. A CPK ($11.75) 48 hours or more after a suspected myocardial infarction, a PBI ($9.70) following an x-ray study using iodinated dye, a serum digitalis level ($24.85) shortly after administering IV Lanoxin, etc. Occasionally studies may be ordered without awareness of absolute need or cost awareness (daily FBS ($7.05), standby oxygen bedside ($4.70/day), IPPB, q.i.d. costing ($8.67) per treatment or $34.68 per day, etc.)

Still other examinations impose untold hardship upon other health professionals. An order for a bedside commode, when an additional two or three steps will bring the patient to a much more comfortable bathroom facility. "STAT" laboratory examinations often impose additional work load for laboratory personnel and overburden an already over-extended department. Timing may also increase costs unnecessarily. Elective diagnostic patient admissions on Friday often prove wasteful since two hospital days may be used awaiting procedures normally performed only Monday through Friday or in emergency situations.

Wide clinical variations among individual physicians is exemplified by a recent study in New Mexico relating to hospital stay and costs during admission for elective cholecystectomy. Certain surgeons in this study kept their patients an average of 6 days in the hospital with one day postoperative intravenous feedings and ambulated patients at the 12th postoperative hour. These charges totaled less than $700 in hospital costs. Other surgeons averaged 10 days hospital stay, 3 days postoperative intravenous feedings and ambulated their patients in 48 hours. The average hospital costs were almost double the preceding group.

To initiate action in this area, I have appointed a special State Committee to take these matters under consideration and make necessary recommendations. To bring this matter more vividly to our attention I would like to offer several suggestions: (1) I would suggest posting of laboratory and x-ray charges in the nursing stations and doctors' lounge; (2) I would suggest the formation of hospital medical staff committees to carry out random selection of charts by the medical staff for cost analysis and necessary corrective suggestions; (3) An analysis of the use of consultants and their subsequent use of diagnostic studies, and (4) A thoughtful review by hospital administration (with medical staff advice) of costly or unrealistic departmental charges used to balance losses in other departments, i.e., a $16.50 charge for the brief use of an emergency department examining room for an inpatient ENT examination.

This entire area of health care cost is beginning to receive national attention. Our patients and our membership can best be served by careful professional analysis of these matters with appropriate voluntary action upon the part of our profession.

Vernon B. Astler



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

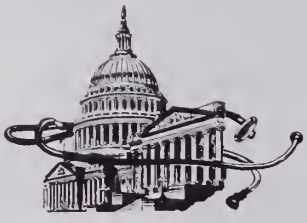
11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005



LEGISLATIVE NEWS

April Showers

We must not forget that besides our major effort to pass professional liability legislation in Tallahassee, we have many other irons in the fire, many of which have long range effects on our daily practice of medicine. The subject of this month's column is legislative items other than professional liability legislation. This is by necessity a very incomplete list, as something over 300 bills having some potential impact on the practice of medicine will be introduced into the legislature this year.

A bill that you should be aware of is HB2740, sponsored by Rep. Karen Coolman of Fort Lauderdale. It changes the present law by deleting the requirement for the legend "substitution allowed . . . prior approval required" and states that a pharmacist "may substitute any less expensive generically equivalent drug product for the brand name drug prescribed unless the prescriber writes the words "medically necessary" in his own handwriting, on the face of the written prescription." This would open much potential for harm to the patient, and FMA is opposed to this legislation. We feel that the present law adequately protects the consumer and that no change is necessary. Rep. Coolman has also sponsored HB2617, which would require a sign to be placed in your office stating "consult your physician concerning the availability of the least expensive drug for your use." This parallels the sign presently in the druggist's place of business. These two bills are representative of the type of so-called consumer legislation that crops up each year. It takes time and effort to explain our position and to defeat or significantly amend such proposals.

Of greater potential impact is CSHB1705 by Rep. Fortune of Jay, Kuten of Miami, and Tucker of Tallahassee, which would establish a health care cost containment program in Florida. It authorizes a commission to review the projected annual revenues of any hospital or nursing home and approve the rates proposed to generate that revenue. It also would prohibit rates other than those approved. This would make hospitals and nursing homes into public utilities as has been done in Maryland with disastrous results to hospitals. It also opens the door to including charges of so-called hospital based physicians, and once this group is swallowed by big brother,, the remainder of medicine is not far behind! The FMA is working to establish a voluntary cost committee that is broadly based in order to have facts available to put this sort of legislation to rest. The FMA will support legislative efforts to require uniform reporting of hospital and nursing home financial data to a state agency, so the facts can be brought out for all to see, but we are opposed to rate regulation.

In the area of licensure, HB2534 (Lewis) HB2456 (Hazelton and Lewis) HB1899 (Morgan) and SB55 (Meyers and Lewis) all further reduce the qualifications necessary to become licensed in Florida, or would grant limited licenses for physicians to practice under certain geographical and/or financial restrictions. The position of the State Board of Medical Examiners is that the present law is flexible enough. Passage of FLEX or the National Board of Medical Examiners examination within the reasonably recent past assures good quality practitioners working in Florida providing the necessary continuity of care.

Availability of health care is a hot issue with a large number of legislators, the FMA's position before the legislature includes support for projects set up by local health departments to provide screening or outreach clinics for senior citizen areas, inner city areas, and rural areas where a demonstrable lack of health care exists. There is existing statutory authority for this. Palm Beach County Medical Society

already is working with the local health department to put such a project into reality. Our position also includes an exceleration of the State Board of Medical Examiners using existing temporary licensing authority to get practitioners into communities of less than 7,500, increased funding for family practitioners and other primary care residencies, scholarships for students who agree to serve in areas of critical need, and low interest loans for start up costs in such areas. We also are asking for real estate developers to submit health care impact statements for new developments to alert nearby communities of increasing demands on their facilities as well as to put a potential buyer on notice as to the availability of health care.

HB2528 (Steinberg) requires all hospitals, nursing homes and health care providers to submit an itemized statement to the patient, who then has 14 days to say to the insurance company whether or not he received the services indicated. If the patient says not, the provider must prove that he did indeed provide the services. Section a(1) requires a hospital to provide an accurate and **legible** copy of the physicians order sheet! The insurer may not pay the statement during this period, but the bill does not state what the insurer may do if the patient does not respond after 14 days. This bill is very burdensome on all those affected for obvious reasons, and will accomplish no benefit to the insurance policyholder except to increase the cost of his insurance.

A question regarding the effect of Florida's Good Samaritan Law came up at the last House of Delegates session and the following is an opinion by John Thrasher, attorney for PIMCO:

THE FLORIDA GOOD SAMARITAN LAW

The Florida Legislature in 1965 followed a precedent set by many other state legislatures by adopting a "Good Samaritan Act." The act, which was effective as of July 1, 1965, applies to any person, including a physician, who in good faith renders emergency care or treatment at the scene of an accident without the objection of the victim. The effect of the act is to **insulate** the Good Samaritan from any civil liability which might arise as a result of such care **provided that the Good Samaritan acted as an ordinary reasonably prudent man would have acted under same or similar circumstances.**

It is obvious that this statute does not provide an individual with absolute immunity. Since there are few court decisions construing these types of statutes, it is difficult to distinguish what acts might not be reasonable under the circumstances. Clearly those acts that could be described as willful, reckless, or grossly negligent would not come within the protection granted by the statute. Moreover, the standard of reasonableness a physician would be expected to adhere to in a "Good Samaritan" situation would be consistent with his individual capacity as a physician as opposed to an ordinary citizen.

The sum total of all of this seems to be that even though there is some statutory protection provided for "Good Samaritan" care, the individual physician could possibly be liable for acts that are clearly negligent within the context of the circumstances.

On the positive side, HB617 (Forbes & Steinberg) provides that health insurance companies must offer catastrophic health insurance with a $3,500 per family deductible. Above this level the policy would pay 90% of expenses with no upper limit. The bill ensures that such coverage would be truly comprehensive. As the FMA's opinion survey indicated, this fear of financially devastating illness is expressed by nearly 80% of Florida citizens. This bill addresses that need and is worthy of our support.

If you have any questions about this or any other pending legislation contact Scotty Fraser in Tallahassee for more detailed information. You are encouraged to communicate with any member of the Committee on State Legislation at any time you feel appropriate.

JOHN C. KRUSE, M.D., Chairman
FMA Committee on State Legislation
Jacksonville

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We start our third century with an increase in the first class postage to thirteen cents. Is this a bicentennial gift from the Post Office in honor of the original 13 colonies? It must be, because they closed the Post Office at noon that day, the day of the announcement. As I was standing in the line awaiting my turn at the stamp machine, it occurred to me that this could be a preview of what government run medicine would be like in the future—continued price increases, inefficiency, confusion, long lines and poor service.

Perhaps the government will develop a medicine dispensing machine, which, like the stamp machine, jams from overuse.—**Harry D. Wassel, M.D.,** in The Picomeso Mail Bag of the Pinellas County Medical Society, Inc.

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Dean's Page

Standards of Quality in Medicine

Donn L. Smith, M.D.

As one considers standards of performance in medicine and their induction and maintenance, a prime question might be—Where does the process start?

Our forebearers obviously believed that the start should be in the College of Medicine. Devotion to duty, acquisition of a core of basic knowledge, respect for the human entity involving both patients and colleagues was firmly inculcated in every student prior to the award of the cherished M.D.

It would seem that as time has passed, a variety of circumstances may have eroded this concept within the halls of academe. The development of a sophisticated system of Specialty Board Certification, ever lengthened periods of postgraduate training for house staff, intense competition for admission to the Colleges of Medicine and an enormous increase in demand for medical care have introduced what appears to be a significant reduction in concern related to undergraduate standards of performance.

The 74th Annual Report on Medical Education (1975) from the AMA shows that in the 1973-74 academic year, of 50,217 undergraduate students of medicine, a total of 237 withdrew or were dismissed because of poor academic records.

This figure of 237 out of 50,217 could be construed as little less than amazing. An attrition rate of .47% due to academic failure is a very low figure indeed. It is doubtful that any other endeavor involving human selection can compare with a 99.+% success rate.

Some absolutely amazing legends have grown into almost factual proportions around the great decrease in medical school attrition rates. The most widely quoted is that everyone admitted has survived a highly competitive screen and thus must certainly be able to handle the medical curriculum. A curriculum which has literally exploded in terms of content and sophistication of material to be learned. Another statement often made relates to the effects of the development of full-time faculties of excellent teachers, who presumably devote large amounts of time to instruction at the expense of tenure and promotion earning research and publishing activities. The reader is left to his/her own experience as he/she evaluates the actual factual content of the above statements.

Coincident with reduced attrition rates, there has developed a malpractice crisis of no mean proportions, major strikes by M.D. house staffs, ever larger health insurance premiums and a cry for socialized medicine of some kind. The physician's image has faltered, and a variety of other problems have arisen to beset the profession.

Even the hint of a suggestion that a potential relationship could exist between current attrition rates at the undergraduate level, a limited failure rate at the house staff level and any of the problems listed above will be unacceptable to many. There may well, in fact, be no causal relationship and I am sure that we all hope that there is none. Even so, a few factors might be considered as one gives some thought to the situation.

Although admission to medical school is indeed highly competitive, and there is little doubt that grade point averages and MCAT scores are higher than ten years ago, the one essential quality that admission committees cannot truly and accurately measure is motivation. The basic ability to do the work, even if granted, is only part of a subtle and delicate human equation. A certain innate drive and

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

desire must also play a significant role as the student forces his/her way through the enormous maze of fact, conjecture and hypothesis education. Further, we must consider the possibility of grade inflation, the effect of the Buckley Act on letters of recommendation, and the true meaningfulness of test scores. In view of these complications, the fact that admission committees whose members have many other pressing tasks could so adeptly choose students to the extent that only 250 of 50,000 fail to master the material must be considered as a feat of most remarkable proportions.

As is occasionally stated by applicants, the hardest part of medicine is gaining admission. Such a viewpoint is certainly understandable whether it is a valid concept or not. In any case, I would question any tendency towards automaticity in progress once admission to the School of Medicine, or acceptance into an academically situated house staff program has been achieved.

One can only hope that over 49,500 of our 50,000 medical students are indeed functioning and learning at full potential and that no ineffectual learners, or anyone with ethical or moral deficiencies or poor motivation is being awarded the M.D. degree.

If this is indeed the case, brighter days must surely be ahead for the profession.

▶ Dr. Smith, University of South Florida, Tampa 33620.

DREAMING THE IMPOSSIBLE DREAM

A recent story in this newspaper about the rapid rise in malpractice judgments against attorneys and the consequent rise in malpractice insurance premiums propelled us somewhere over the rainbow into a delicious reverie about a possible result. Suppose that the attorneys followed the lead of doctors in Los Angeles and other parts of the country and protested the higher premiums by engaging in a work slowdown, or better yet, a strike?

What would life be like if the great law firms and the solo practitioner stayed home, clogging the golf courses and tennis courts of America? It would be Paradise Regained. The normal intercourse of life would flow smoothly, unchecked by the law's and the lawyer's limitless capacity to complicate and tangle things. Disputes would have to be resolved by common sense and mutual trust, rather than on the basis of who could hire the fastest gun. The wheels of commerce would turn more swiftly as people without special training in obfuscation and logic-chopping made clear and understandable agreements. Individuals with disagreements would have to rely on their own capacities for reconciliation and forgiveness instead of the brutalities of specially trained gladiators. The pleasant consequences are virtually limitless, and include not having to pay huge legal fees.

But lawyers are a clever group. They know better than to go on strike, no matter what the provocation. They know that people would learn, all too soon, that things worked perfectly well, or even better, without them. Oh well, it's nice to dream.

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ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

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The Annual Scientific Meeting of the Aerospace Medical Association will be held May 10-13, 1976 at the Americana Hotel in Bal Harbour.

I would like to extend an invitation to any FMA members who are interested in attending our meeting at Bal Harbour. We will have a well rounded program covering all aspects of aviation and space medicine and in addition there will be a 4 day FAA conducted Aviation Medical Examiner seminar.

Our Association is approved by the AMA for Category I Continuing Medical Education and attendees at our meeting may receive full Category I Credit.

Your members will be most welcome.

Merrill H. Goodwin, M.D.
Executive Vice President
Aerospace Medical Association
Washington, D.C.

Dear Mrs. Astler: I read your editorial in the February issue of the JFMA with great interest and agree with you 100%.

It is certainly nice to see clearcut, simple suggestions made to the ever-increasing complexity of our social, economic, and political problems.

Your title said Part I. I will look forward eagerly to Part II—including your critique on the unsavory scenes in the medical profession as well.

Neal A. Robinson, M.D.
Eustis, Florida

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Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99 7%	99 9%	—
(range)	(70-99%)	(99 5-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.
PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

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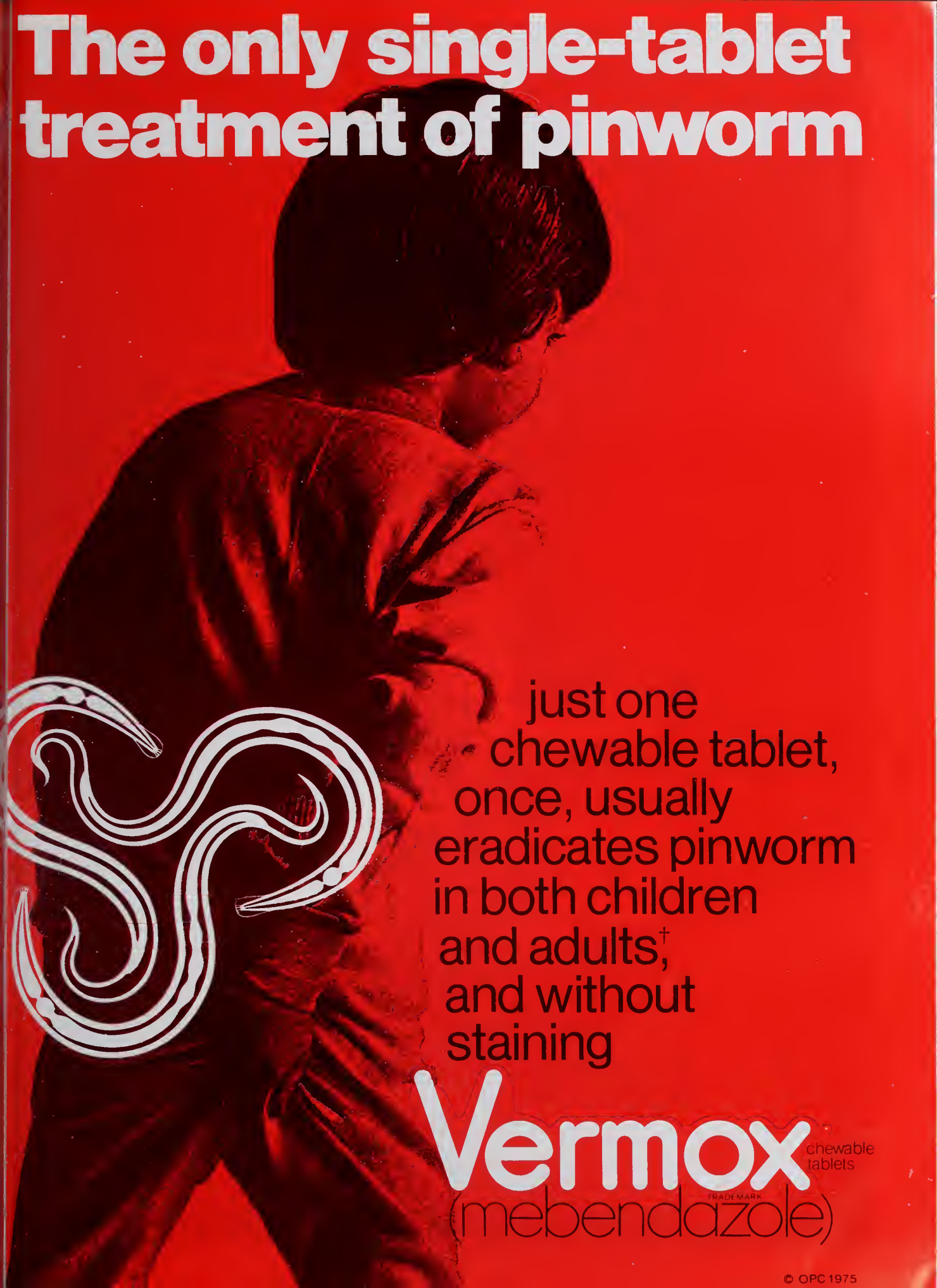
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Early Strategies in Treatment of the Depressed Patient

Jose J. Llinas, M.D.

Abstract: Management of most depressed patients is well within the capability of the family physician, provided that he is willing to upgrade or develop skills in four basic areas: 1) engaging the patient in a trusting relationship; 2) appraising lethality in suicidal crisis; 3) using antidepressant medication correctly; and 4) being aware of the psychiatric resources within his own community, for those patients he can not or will not treat himself.

Depression accompanying physical or emotional disease or as a symptom complex in its own right is one of the most common complaints. Understanding and managing it adequately is a very useful skill for any practitioner whether in general medicine or a specialty.

Definition

Depression is an unpleasant state of low spirits manifested by sadness, crying, feeling of helplessness, lack of interest in the environment, retardation of activity and intellectual functions, and a definite sensation at times that something very important is lacking in one's life.

From the mildest states, related particularly to grief situations, to the severe suicide-prone depression of the psychotic patient, there is a wide variety of increasingly more troublesome conditions.

Understanding Depression

Perhaps the best way to obtain some insight into the nature of this affliction is to compare it to the very common human reactions of grief and bereavement. In fact, this was originally done in the early part of this century by two psychiatric pioneers, Karl Abraham and Sigmund Freud.

Abraham first pointed out the similarities between the common state of mourning and pathological depression.[1] In both situations, the patient usually is overwhelmed by feelings of pain and sorrow. In the former, the feelings seem justified by the loss of a loved person; in the latter, no such loss can be identified at times. Freud took the comparison a step further and pointed out that one of the basic differences is that even though the grief-stricken person feels very bad, he doesn't usually blame himself for the situation; the tragedy did not happen to him because he is either inadequate or "bad." In other words, the person in mourning retains a healthy amount of his regular self-esteem. He may have a sense of loneliness and abandonment but still feels reasonably good about himself.[2]

The markedly depressed patient, on the other hand, depending on the intensity of his problem, struggles with very severe feelings of worthlessness and self-blame. If these feelings are mild, the person thinks that he is "inferior," "not good enough" or "inadequate." If the feelings are very intense, derogatory self-accusations take a paranoid coloring. The individual may think of himself as being the world's worst sinner, having indulged in unpardonably evil behavior or about to receive punishment of catastrophic proportions in accordance with the supposed gravity of his transgression.

Nature of Self-Blame

This was the first psychological puzzle about depressive feelings that Freud felt he could understand.

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Why does the depressed person accuse himself so much? The answer lies in the nature of the response to the loss and is manifested by the accusations and the direction in which they turn. The patient feels vaguely, if he is not too disturbed, that he is a bad (aggressive) individual and that is why he is being abandoned or experiencing the loss. In reality the feelings represent his own anger when confronted with the loss. If he is seriously upset, then he is convinced that he is indeed a very evil and destructive person. These accusations directed against the self were probably not self-directed originally. The depressed patient is going through a process where he accuses himself of things he felt at one time were somebody else's responsibility . . . that somebody else being, naturally enough, the person who abandoned him and caused his affliction. In other words, when the patient feels he has been abandoned by somebody he loves, he becomes extremely angry and it is this anger (directed against what he sees as cruel rejection by the loved, deserting person) that he now turns upon himself.

Reasons for the Symptoms

The mechanism provides both for the expression of rage and also for somehow keeping up the relationship with the deserter, now in some ways identified with the self. The accusations can then be understood as the complaints (the grudges) the patient has against whoever mistreated him. In a way, his hated enemy is now resented within. Not all the aggression is bound up in this manner. Enough seeps out so that whoever happens to be around gets some of it. This psychological theory makes a good deal of sense out of common clinical happenings with the depressed patient.

For instance, one seriously depressed patient is so critical of himself he feels he doesn't deserve anybody's attention . . . but goes around moaning and groaning in such a way that everybody has to pay attention to him.

Another patient calls her psychiatrist at 3:00 a.m. asking if it is all right to take another sleeping pill since she does not want to do anything that could even remotely go against the doctor's wishes. She doesn't want to get the doctor upset.

Some of the bittersweet, insightful jokes about the "Jewish mother" situation carry this obvious connotation.

> A boy was getting married and called his elderly widowed mother, who lived in a small apartment in the city, to let her know.
>
> "Wonderful", his mother said, "now you and your wife will be able to move into my apartment." "But mother," the son protested, "your place is too small!"
>
> "It won't be," the mother sighed, "when I drown myself in the bathtub!"

Bitter recrimination or more subtle techniques of mobilizing guilt in another person are the stock in trade of some chronically depressed patients. They are usually people who have suffered this kind of treatment in their own early lives at the hands of their parents.

Personality Traits

An understanding of the dynamic relationships involved in depression makes it clear that certain conditions are needed beforehand to produce this kind of reaction in a person. While there is a great variety of personality types, certain specific clusters of personality traits are apparent in most people who are prone to depressive feelings. No single person will show all these characteristics or demonstrate them with similar intensity but the alert physician can easily identify at least some in all seriously depressed patients.

1. They are sensitive. Their feelings are easily hurt though they may not necessarily show it. Some tend to nurture slights and rejections, imagined or real, for long periods of time.

2. They are usually very conscientious, have a strong sense of duty, tend to be perfectionistic and blame themselves if things don't go well. Their self-esteem is a problem and many complain of inferiority feelings or a sensation of general inadequacy. This is particularly true in their limited ability to express feelings and relate freely to other people.

3. Many tend to be rather compulsive and rigid in their activities and become very easily upset if changes come about. Their reaction of resentment when a loss occurs in their environment is probably tied to this factor and to another one which is perhaps more important, their usual ambivalence of feelings. They are prone to have a mixed emotional reaction particularly towards people who are very important for them. It is difficult for them to love completely and, therefore, very easy for them to resent.

4. Perhaps because of their inability to communicate with others, they tend to retreat into themselves a great deal and self-centeredness is a problem many times.

5. Their orientation to life, though they seldom realize it, is somewhat demanding. They have very high expectations of themselves and of other people.

Their need to get nurturance, support and approval from others is very great, although it may not be expressed openly because of the previously mentioned difficulties.

Clinical Management

The first step in attempting to help a depressed patient is to establish a relationship. It is only when the patient can develop some confidence in the physician that it is possible for them both to begin to look at what is in reality happening.

Unfortunately, many patients are not able to do this because they are not capable of developing enough of a trusting confidence in the doctor. Some patients can be helped, however, with a generally supporting and accepting attitude since they tend to see the problem in what they consider "medical" terms. In fact they may deny being depressed and complain instead of being tired, lacking energy, and sometimes truly believe they are suffering from a physical disease. They want some kind of tangible, "medical," help from the doctor though they often tend to react with worsening of the symptoms or become openly critical about the doctor's approach.

A rigid and perfectionistic 45-year-old engineer was referred by his internist with a problem of feelings of discouragement and worry, related in part to having lost his job, because he was unable to do what he considered lowering of his professional standards in working for the state. Since he did not seem very insightful and was tremendously threatened by the visit to the psychiatrist, it was decided to place him on a tricyclic antidepressant. He returned the following week with the complaint that the medication had made him feel "dopey and groggy." Although insomnia had been one of his complaints and the medicine, he said, made him sleepy at night, he did not consider this any help and after consultation with his internist, decided to discontinue the medication. It seemed to have been very important for him that the psychiatrist would take no credit for the improvement, however mild, that he was experiencing.

How much work needs to be done depends, among other things, on the intensity of the problem, the interest and possible skill of the physician in the area of psychological counseling, and, of course, the kind of relationship that can be developed.

Mild Grief or Depression

When the depressive syndrome is relatively mild, it generally indicates that the loss is not a severe one, that the ability of the patient to withstand it is reasonably good, or that both of these statements are true. Most patients in this category will improve quickly, regardless of treatment.

In training beginning therapists, supervisors of residency training programs are cognizant of the fact that assigning a mildly depressed patient to a young therapist is usually a good idea, since the patient will generally improve and the trainee will be rather happy and encouraged about the positive results of his efforts at psychotherapy.

Moderately Severe Depression

If the loss that has occurred or with which the patient may be threatened is a more serious one, such as grave illness in a close relative, serious possibility of losing a job, or any other important life crisis, the patient may react with a more severe and usually agitated depressive syndrome. This situation requires more careful and skillful management. It usually involves an ability to help the patient recognize and understand his feelings, particularly those of anger and resentment.

A 26-year-old housewife and mother of two small children was referred to a psychiatrist by a nurse relative with the explanation that the patient was extremely upset, unable to eat or sleep properly, barely able to take care of the children and do her household duties, and verbalizing suicidal preoccupation. As soon as the patient came into the office she blurted out that her husband of six years had died of Hodgkin's disease a month prior to the referral. The husband had apparently been ill for most of the years of their still young marriage and even though she said she had attempted to prepare herself for the inevitable, his death came suddenly and during a period of remission which had allowed him to return to work. It was very obvious that among the confusion of feelings, a great deal of hurt and anger and feelings of abandonment related to the severe blow that fate indeed had dealt her, were very prominent.

At the end of the interview, a few general comments were made about this and it was explained to her the work that needed to be done. Surprisingly, she never returned, but indirect follow-up through the relative disclosed that she had calmed down considerably after the discussion with the psychiatrist and seemed more able to cope with the situation. While this result was somewhat unexpected, a short series of interviews at a time of crisis of this type, where the patient recognizes what she is struggling with, usually produce very favorable results.

Severely Depressed Patient

Some patients get so upset that their vegetative functions are severely impaired. They are extremely restless; "can't sit still." They don't sleep well at all and lose their appetite. Others develop marked motor retardation and may stay in bed for days on end. In still others, the feelings of guilt, never absent in serious depressive syndromes, become so intense they reach the strength of delusional thinking.

Severity may also be related to the fact that, while in the beginning the patient is not seriously disturbed, he or she somehow fails to improve despite appropriate counseling and psychopharmacological treatment.

With either type of patient, severe suicidal preoccupation is an indication for temporary or more definitive hospital management.

A 36-year-old married woman returned from a funeral and was so tired and wrought up that she called the neighbor across the street to send her two children, for whom she was babysitting, home. While crossing the street one of the two children was unexpectedly run over by an oncoming truck and died instantaneously.

By the time the patient was seen in the emergency room a few hours later, she appeared in a state of stupor and kept repeating, "My baby is alive, my baby is alive!" At the same time she seemed to blame herself and said to the distressed husband several times that she "deserved to die for not going and picking up the kids herself." After a few days of hospitalization and supportive treatment, where acceptance of her immense grief was encouraged, she settled down into a slowly resolving depressive reaction of several months duration during which she was followed in outpatient treatment.

Problem of Suicide

Important and life-saving as it is at times, no physician should labor under the misconception that putting the patient in the hospital is a clear solution to all, or even most, of the suicidal crises. In the first place, the incidence of suicide in mental hospitals themselves, for obvious reasons, is about three times the rate in the general population.[3] In the second place, the best alternative to suicidal behavior is a productive, protective human relationship, a "life-line." If the patient realizes that somebody cares and is willing to stand by him, feelings of helplessness and "giving up" may be easier to overcome or even to live with. Suicidal crises tend to be time-limited events and the importance of keeping the patient going is tied to the hope that if he can cope with the crisis he may get on top of the situation.

Appraising Lethality

One of the most important skills a physician should acquire is an ability to evaluate how dangerous the situation is regarding self-destruction. General guidelines in this area can be summarized along four different parameters.

The first is the patient's clinical condition. Is he mildly, moderately or seriously depressed? If seriously depressed, is he eating and sleeping? How intense are the feelings of guilt, low self-esteem and how much self-loathing does he verbalize? How hopeless is his outlook? Are there any psychological barriers (religious, cultural, familial) against self-destruction? Or, on the other hand, has the taboo against suicide already been broken in his family by the self-inflicted death of a close relative?

The second is the seriousness of the suicidal preoccupation itself. Does he vaguely think about "taking a bunch of pills" or does he have a reasonably complete suicide plan with a high possibility of lethality? (9/10ths of completed suicides in this country involve the use of firearms, hanging, poisoning or asphyxiation).[3]

Third, has there been a recent important loss or dislocation in his relationships that the patient feels he cannot cope with?[4]

Fourth, what is his age, sex, civil status, religion, life style, family situation?

Statistically, men are more likely to commit suicide than women; older people than younger; single, separated or divorced more often than married; alcoholics and drug abusers more often than people with a less destructive lifestyle. Prior suicidal behavior is a dangerous sign, particularly if the attempt was serious enough. Completed suicide in a close relative, as previously mentioned, is equally risky.

Finally, the question may come up, why should one try to appraise lethality so carefully and spend so much time developing the skills to help the suicidal patient or intervening in the suicidal crisis? The best answer I know is that given by Dr. Edwin S. Shneidman, former chief of NIMH's now defunct Center for Suicide Prevention. He was trying to convince the Bridge Authority of famed Golden Gate Bridge in San Francisco, where 391 people have jumped to their death, that a barrier should be placed around the leaping area. The authority argued that if it stops the bridge jumper he will only go somewhere else to take his life.

"If a person cannot commit suicide when and where he wants in an impulsive moment," Dr. Shneidman retorted, "he might just say the hell with it."[5]

Physician, Heal Thyself

In some ways we, as physicians, have a house to put in order before we can begin helping other groups of people. Throughout the years a number of reliable studies have shown a very high rate of suicide among physicians and the highest one of all among psychiatrists.

Calling it "an appalling phenomenon," Dr. Stanley I. Holzberg, from the University of Miami, feels that the only long-term solution to the problem is to teach and openly discuss the special physical and mental health problems of doctors in medical school "so that we can begin to meet our medical obligations to our colleagues and not continue to force faltering M.D.'s to literally attempt to heal themselves."[6] In a companion article the American Medical News scored the fact that more than 90% in a group of physicians surveyed thought their knowledge of how to help suicidal patients was poor and certainly insufficient.[7]

It has been pointed out that most physicians who commit suicide are themselves depressed and melancholy.

"One half of those (physicians) who suicide," says Dr. Philip M. Margolis, from Ann Arbor, "take drugs which are readily available; with his adequate

toxicologic knowledge, the doctor is unlikely to misjudge the mortal dose."[8]

What practical advice can be given to protect the physician? Most important is to become aware of the seriousness of the problem, and for the doctor to seek and accept help as any other human being. Physicians' ideals are at times too high, they neglect recreation, and are not able to work out the role strain implicit in their professional tasks. This requires much positive change in the doctor-doctor relationship but there is little question it could be done.

Referral Process

Once the patient has been classified as suffering from mild, moderate or severe depression and the suicide potential has been appraised the physician is ready to proceed. Obviously the most severe cases or those the doctor feels uncomfortable about managing himself should be immediately referred to a competent psychiatrist. Unfortunately this is an area where usually the physician receives very little guidance. Yet it is important that he do a good job and avoid any pitfalls.

As for the patient, depending on how much insight he has into the situation, his feelings about emotional problems, his degree of psychological sophistication and trust in the physician and many other factors, he may react negatively to the recommendation, particularly if the doctor makes it in an abrupt or authoritarian manner. One good way to proceed is to summarize both the subjective complaints and the objective signs visible to the physician. Then one can ask the patient whether he agrees or disagrees with the doctor's appraisal and clarify the situation further as necessary.

"Fortunately," one can then say with confidence, "there is a good deal we know about depression these days. I think we need some of this expert advice and management and I am going to arrange for you to see a specialist."

If the patient is in such a state of mind that he is not capable of following the suggestion, help from relatives can be enlisted and, if necessary, involuntary commitment to a hospital worked out. Most busy physicians are not well informed in this latter area. Because of that and also because when they make a strong recommendation they should make sure they have appropriate back up, it is ideal if the doctor is familiar with the psychiatrists in the region as well as other mental health resources which might be available.

In practical terms the physician should know at least one psychiatrist or mental health professional, preferably in his own community, whose approach and understanding he (the physician) is comfortable with and can honestly support. There is no sense in referring a patient who needs to be seen right away to a man who has a rigid two-week or longer "waiting list." No matter what the physician has heard, psychiatric practitioners are basically no different than other specialists. Their professional livelihood is tied in most cases to appropriate referral patterns and they are usually quite happy to cooperate with a colleague.

There may be, in one's own community, a mental health center, clinic, psychiatric unit in a general hospital, family service agency or nonmedical private practitioners (usually psychologists). The physician needs to find out about these resources and how helpful they can be before he is confronted with the seriously depressed patient or one in a clear suicidal crisis.

Pharmacological Approach

Management of simple grief or reactive depressions is relatively easy. When the environmental loss is not clearly apparent or the symptoms are of sufficient intensity and duration, one often effective alternative is the use of antidepressant medication.

In an excellent article, Jerome A. Motto states that the nonpsychiatric physician is "more and more in a pivotal position regarding the identification and management of depressed and suicidal persons."[9] "It is essential," he adds, "that the physician resolve his own anxiety about suicide in order to function most efficiently in this role. Only when this is achieved will principles of management and treatment have value." He made a further statement, however, which opened up a hornet's nest in terms of controversy with a fair number of competent clinicians and researchers taking stands pro and con in the letter columns of JAMA. The statement was:

> "Aside from the value of psychotherapy, I have been unimpressed by what are called antidepressant drugs (imipramine hydrochloride, amitriptyline hydrochloride, etc.). Notwithstanding many distinguished voices to the contrary, I fail to find even reasonable (not to say convincing) evidence of antidepressive effects in my own depressed patients, and have yet to see a well designed and executed clinical investigation that demonstrates more than a mild tranquilizing benefit. It is safe to say that any agent that relieves despondency will soon be misused

by a large number of drug-prone persons who now misuse alcohol, amphetamines, marijuana, etc. I believe we can rest assured that current antidepressants will never reach the black market."[9]

This is probably an extreme position, and in one of the most recent and highly respected psychiatric textbooks, Cole and Davis, after reviewing the evidence carefully, state that there is demonstrated antidepressive efficacy in the preparations criticized by Motto.[10]

What is perhaps of more importance to the practicing physician is the fact, agreed upon by most psychiatrists, that the antidepressant effect is not as dramatic and immediate as, for instance, the reliably calming effect of phenothiazine tranquilizers. This presents an added problem, which is patient noncompliance, since it is hard for an apathetic and despondent individual to go on taking a medicine which "doesn't do anything for me."

The early psychological engagement of the patient, as previously described, is therefore essential to successful management.

Antidepressants

"In 1952, in a small tuberculosis sanitarium adjacent to one of the many little beaches that abut New York City," narrates Sidney Malitz, "a group of patients began behaving in such a strange manner that they made headlines in a national magazine. Previously weak, tired, and depressed from their chronic, debilitating illness, they suddenly took a renewed interest in living, became euphoric, and started dancing up and down the aisles between their neatly symmetrical ward beds."[11]

Those patients were being treated with a then new drug, Iproniazid, which a few years later was used to treat conditions where apathy and depression play a major role. Unfortunately, Iproniazid and similar derivatives, classified as monoamineoxidase (MAO) inhibitors, turned out to be extremely toxic to the liver and their use had to be discontinued, at least as regards the earlier compounds.

Another drug, introduced in 1957, was more felicitous both in terms of moderate but reliable antidepressant activity and fewer and less troublesome side effects. Imipramine, belonging to the iminodibenzyl group, has a slow, gradual effect of mood elevation; it has been extensively investigated and has led to the discovery of a number of related drugs which are now widely used. As one of the standard texts puts it, these agents "are prescribed now as the initial form of therapy for the majority of patients suffering a depressive reaction."[12]

Mention should also be made of a drug which is now considered specific for the treatment of the manic phase of manic depressive psychosis as well as chronic hypomania, lithium carbonate. The standard textbooks offer clear guidance in the use, indications and side effects of these compounds.[10-12]

In general practice, probably familiarity with the action of imipramine (Tofranil) and amitriptyline or nortriptyline (Elavil, Aventyl) will suffice in the vast majority of cases. Consultation with an experienced clinician is probably more prudent in cases which fail to respond in a reasonable period of time or constitute a serious management problem in any other way. Electroconvulsive therapy is still indicated in psychotic and severe psychoneurotic depressive reactions, particularly if the suicidal danger is so strong that one dares not wait for the slower effect of antidepressants.

Summary

Patients with depression are commonly found in the general practice of medicine. Adequate psychological understanding of their problems, familiarity with suicide risk assessment and use of antidepressant medication are useful skills that the general physician can develop and incorporate into his approach, usually with positive results.

A knowledge of private and public psychiatric services in his own community is also of the essence, particularly for appropriate management of the occasional patient in suicidal crisis.

References

1. Abraham, K.: Notes on Psycho-analytical Investigation of Manic Depressive Insanity and Allied Conditions, Selected Papers on Psychoanalysis, Basic Books, New York, 1953.
2. Freud, S.: Mourning and Melancholia, Collected Papers, Vol. 4, Basic Books, New York, 1959.
3. Weiss, J. M. A.: Suicidal Patient, from Arieti, S., ed., American Handbook of Psychiatry, Vol. III, Chap. 8, Basic Books, New York, 1966.
4. Shneidman, E. S., and Mandelkorn, P.: How to Prevent Suicide, from Shneidman, Barberow and Litman, eds., Psychology of Suicide, Chap. 7, Science House, New York, 1970.
5. Time Magazine, Aug. 24, 1970, p. 40.
6. Holzberg, S. I.: Physician Suicide, Appalling Phenomenon, Am. Med. News, Dec. 17, 1973, p. 14.
7. Suicide—A Tragic Toll, But Still a Taboo Topic, Am. Med. News, Dec. 17, 1973, pp. 11-13.
8. Margolis, P. M.: M.D. Suicides . . . Why? Michigan Med., May 1968, p. 589.
9. Motto, J. A.: Toward Suicide Prevention in Medical Practice, JAMA 210:1229-1232, 1969.
10. Cole, J. V., and Davis, J. M.: Antidepressant Drugs, from Freedman, A. M., and Kaplan, H. I., eds. Comprehensive Textbook of Psychiatry, Williams and Wilkins Co., Baltimore, 1967.
11. Malitz, S.: Drug Therapy: Antidepressants, from Arieti, S., ed., American Handbook of Psychiatry, Vol. III, Basic Books, New York, 1966.
12. Kolb, L. C.: Modern Clinical Psychiatry, W. B. Saunders Co., Philadelphia, 1973.

▶ Dr. Llinas, 3615 S. W. 13th Street, Gainesville 32608.

Editorial Comments

This paper is quite appropriate for publication in the FMA Journal. It is broadbased, practical and directed to physicians in general rather than the specialty group. Very worthwhile in comments about physicians' problems and the evaluation and treatment of the suicidal patient.—Deborah Coggins, M.D., Gainesville.

This paper should have a wide range of interest for the general practitioner and internist. It emphasizes to a considerable degree the approach to a patient and does not go into drug therapy in detail which is probably a wise point since this information is readily available elsewhere. I think this paper is worthwhile and of interest.—A. Lee Messer, M.D., St. Petersburg.

Simplistic and straight forward. An excellent article for a general Journal. Should be easy for any practitioner to restructure his thoughts about a subject he sees every day but tends to ignore, i.e., depression.—Jack W. MacDonald, M.D., Tallahassee.

Join glowing program
Government promises.
Late fiscal default.

Working together
Solving problems locally.
A glimmer of hope?

Brown surf from sea storm.
High tide line full of debris.
Treasures on the beach.

Childhood cancer kills
Far more than the child alone.
Oncology blues.

Humble haiku composed by Dr. Charles G. Eschenburg, Delray Beach. This is a Japanese form of poetry consisting of 17 syllables, usually leaving much to the imagination of the reader.

A New Era for Tuberculosis

Allan L. Goldman, M.D.

Abstract: Tuberculosis is still very much with us. With reduction in sanitarium beds, care of the tuberculosis patient has been transferred to the community. This has not been capricious but a well-thought out transition based upon better knowledge of the epidemiology of the disease and the availability of potent antituberculosis drugs. The development of active disease in "infected" patients can be prevented with isoniazid. In the treatment of active disease, isoniazid plus ethambutol is a safe, well-tolerated regimen which is nearly always curative if the patient takes his medications faithfully. On effective chemotherapy, patients rapidly become noninfectious. Studies have shown that most patients can be treated as outpatients effectively without posing a threat to the community. While short-term hospitalization will occasionally be indicated, long-term hospitalization should be a rarity today.

Although the incidence of tuberculosis is slowly declining, it is by no means a rare disease. In 1973 there were 30,998 new cases of active disease in the United States, 1,487 cases in Florida. Although most common in alcoholics and black males, no group is immune. New knowledge of the epidemiology of the disease coupled with very effective, easy to take chemotherapy and preventive therapy have resulted in the closing of most sanitariums with the resultant effect of bringing tuberculosis back into the mainstream of medicine. This article highlights the advances that led to this change and outlines a therapeutic approach that should enable the practicing physician to care for these patients effectively. The interested reader is referred to a recent comprehensive review for further details.[1]

Dr. Goldman is Assistant Professor of Medicine, and Chief of the Pulmonary Disease Section, University of South Florida College of Medicine and Tampa Veterans Administration Hospital. He is also chairman of the Committee on Quality Care for Tuberculosis Patients of the Florida Lung Association.

Preventive Therapy

A patient who has a positive intermediate strength PPD skin test (10 mm or more of induration) but without evidence of active clinical disease is said to have "infection," that is, past contact with tuberculosis which his body has successfully contained. Later in life the tuberculosis may be reactivated and active, and progressive pulmonary "disease" develop. The preventive therapy of the patient with infection but without clinical disease and the patient with active disease will be discussed separately. Because some patients with a positive skin test are likely to have active disease in the future, it is important to recognize them and treat them preventively with isoniazid (INH) 300 mg daily for one year. In children 10 mg/kg not to exceed 300 mg is given daily for one year. Reactivation is most likely to occur and preventive therapy is most beneficial in the following groups of patients:

1. Household contacts (regardless of size of PPD reaction).
2. Recent skin test converters. An individual whose skin test has increased by 6 mm or more from less than 10 mm induration to 10 mm or more of induration within the last two years.
3. Patients with a past history of untreated or inadequately treated tuberculosis.
4. Patients with an abnormal chest x-ray consistent with old tuberculosis in whom bacteriologic studies are negative.
5. High risk patients. a. During immunosuppressive therapy including corticosteroids, b. Postgastrectomy, c. Reticuloendothelial malignancy (leukemia, Hodgkin's, etc.), d. Severe diabetes, and e. Silicosis.
6. Patients under age 20.

7. Patients who are pregnant and also fit in one of the categories 2-6 should have treatment begun in the last trimester.

8. Children who have measles or pertussis, or who receive measles vaccine should have eight weeks of INH if previously treated or 12 months if they have not.

9. All other positive tuberculin reactors on an individual basis, generally those less than age 35 or where the development of tuberculosis could be disastrous, such as in a newborn nursery nurse.

It is important to rule out active disease in these reactors by obtaining a chest x-ray and other studies as necessary.

Patients on INH may have a variety of adverse affects.[2] Those taking diphenylhydantoin or meprobamate may need the dosage reduced due to potentiation by INH. Pyridoxine 50 mg per day should be given to prevent peripheral neuropathy in alcoholic or malnourished patients. Hepatotoxicity must be inquired into by asking if the patient has had a persistent flu-like illness, anorexia, nausea, vomiting, dark urine, light stools or jaundice. If any of these symptoms develop an SGOT should be obtained to rule out hepatotoxicity and if necessary INH discontinued.

Therapy of Active Disease

The definitive diagnosis of active pulmonary tuberculosis still depends upon culturing Mycobacterium tuberculosis from sputum or a tissue specimen. There have been few recent advances in diagnostic techniques. The intermediate strength PPD skin test, chest x-ray and sputum smear and culture remain the major tools.

There have been marked changes in the treatment of active pulmonary tuberculosis over the past 20 years. With the advent of effective chemotherapy the need for prolonged bed rest, dietary supplements, exercise and fresh air became unnecessary and surgical procedures rarely indicated.[3] The recognition that effective chemotherapy judiciously taken cures almost all cases of tuberculosis obviated the need for long-term rest and treatment facilities. This trend began in the early 1960s and has continued; therefore most states reduced the number of long-term tuberculosis beds.

Recently, the epidemiology and transmission of tuberculosis have received renewed interest. Tuberculosis is spread by airborne droplet nuclei liberated by sneezing, coughing, speaking, etc. To develop tuberculosis a susceptible subject must inhale droplet nuclei containing viable pathogenic Mycobacterium tuberculosis organisms. Consequently, the concentration of droplet nuclei and length of exposure are of prime importance in determining the transmission of the disease. For these reasons patients with widespread, untreated pulmonary tuberculosis who are actively coughing and have organisms on smears are highly contagious to close contacts.[1]

Chemotherapy rapidly reduces the infectiousness by reducing the cough, secretions and the number of organisms in the sputum. This rapid loss of infectiousness initially led to shorter hospital stays and recently to the treatment of many patients entirely on an ambulatory basis. Studies indicate that contacts of patients treated entirely at home have no higher risk of tuberculosis than contacts of patients treated in a hospital setting.[1,4]

In most cases patients can be treated in the physician's office or in a local hospital. To be able to effectively care for them, the physician needs to be aware of current standards of care. A patient who has a clinical picture compatible with tuberculosis should have the diagnosis verified through use of the intermediate PPD skin test, chest x-ray, and sputum smears and cultures for tubercle bacilli.

Once a diagnosis is made what should be done? The local health department must be notified so that the patient's contacts can be evaluated for possible infection. Generally, this is done through the use of intermediate PPD skin tests and chest x-rays as necessary. Hospitalization is generally reserved for patients who are toxic from tuberculosis, have a complicating medical condition that requires hospitalization, require an extensive diagnostic evaluation or have complicated drug-resistant disease where close monitoring is essential. The otherwise healthy, relatively asymptomatic patient can be treated entirely as an outpatient.

Patients hospitalized with known tuberculosis who have cough and positive sputum smears should be appropriately isolated in rooms with adequate ventilation and perhaps ultraviolet radiation to reduce the risk of spreading infection. When visitors are in the room patients should wear a mask. Extraordinary precautions such as the use of special dishes, trays and eating utensils are unnecessary. The duration of hospitalization needs to be individualized. After effective chemotherapy is instituted and there are signs of improvement (patient is feeling better, fever is defervescing, serial sputum smears show a decreasing number of organisms, or the chest roentgenogram is improving), the patient can be removed from isolation. Usually, this is within two weeks of chemotherapy. If the indication for

admission has resolved, the patient may be discharged to be treated and followed on an outpatient basis.

Successful treatment of active pulmonary tuberculosis depends almost entirely upon insuring the administration of at least two effective anti-tuberculosis drugs for 18-24 months. Patient compliance in taking the prescribed drugs must be insured because failure is the single most important factor in unsuccessful therapy. The need for prolonged chemotherapy must be made clear to the patient. Patients with newly discovered active pulmonary tuberculosis in whom there is no reason to suspect drug-resistant organisms (no prior therapy and no contact with a drug-resistant case) can be treated with INH 300 mg per day orally and ethambutol 15 mg/kg per day orally for 1½-2 years. All medication can be given at one time, generally at breakfast or bedtime. This combination is a very well tolerated regimen and can be expected to cure 95% of patients if strictly taken. For patients with far advanced cavitary disease the addition of streptomycin 1 gr per day intramuscularly for 60 days may be advisable. Whichever drugs are used appropriate monitoring for toxicity should be done. Isoniazid has already been discussed. Patients on ethambutol should have their visual acuity and red-green color blindness inquired into at each visit since optic neuritis is a rare complication with this drug. Visual acuity can easily be checked by asking the patient to read a newspaper or using the Snellen eye chart if there are any symptoms.

Occasionally, patient compliance in taking prescribed medications is questionable. For these patients the use of supervised biweekly, outpatient chemotherapy consisting of INH 14 mg/kg and either streptomycin 27 mg/kg or ethambutol 50 mg/kg has been shown to be very effective after initial daily triple drug therapy of INH, ethambutol and streptomycin for two to three months.

Successful therapy is evident by improvement as previously outlined. Sputum cultures should be followed monthly until they convert to negative. This should be within six months.

In patients failing to respond to therapy, resistance may be primary (the patient is infected with organisms initially drug-resistant) or secondary (generally due to taking drugs irregularly). Obviously, one must be sure that the patient has actually been taking the prescribed drugs. Drug resistance should be suspected when the cultures remain positive longer than six months or revert to positive after having been negative earlier. Where drug resistance is suspected, sensitivity studies and repeat sputum cultures should be obtained. Then at least two and preferably three drugs to which the organisms are susceptible should be employed. If possible, INH and/or rifampin should be among them. In complicated cases the help of the local health department or a specialist in tuberculosis should be sought. However, these cases are the exception rather than the rule.

After successful therapy, routine follow-up is no longer recommended because the reactivation rate is so low. The patients should be advised that if persistent respiratory or systemic symptoms develop, they should return for reevaluation.

Conclusions

Tuberculosis will be with us a long time. Because it has reentered the mainstream of medicine, it is likely that many of us will treat these patients in the future. From the discussion it is hoped that the practitioner managing a patient with tuberculosis will feel more comfortable with the disease and that he may prevent it from developing in tuberculin positive, high-risk patients.

The references given as well as the county and state health departments can be valuable assets in helping to manage these patients successfully. Your local Lung Association has many free booklets on the different aspects discussed. Tuberculosis can prove to be a very rewarding disease to treat because, after all, how many diseases can we really cure?

References

1. Johnston, R. F. and Wildrick, K. H.: "State of the Art" Review. The Impact of Chemotherapy on Care of Patients With Tuberculosis, Am. Rev. Resp. Dis. 109:636, 1974.
2. Goldman, A. L. and Braman, S. S.: Isoniazid: A Review With Emphasis on Adverse Effects, Chest 62:71, 1972.
3. Fox, W.: Changing Concepts in Chemotherapy of Pulmonary Tuberculosis, Am. Rev. Resp. Dis. 97: 767-790, 1968.
4. Tuberculosis Chemotherapy Centre, Madras: A Concurrent Comparison of Home and Sanitarium Treatment of Pulmonary Tuberculosis in South India, Bull. W. H. O. 21:51, 1959.

▶ Dr. Goldman, 13000 North 30th Street, Tampa 33612.

Editorial Comment

This is a rather complete and accurate summary of the prevention and treatment of tuberculosis. The article is timely since more than 80 percent of the newly reported cases of tuberculosis in Florida are receiving all of their treatment either at home or at home after a short term hospitalization in local general hospitals, and Florida experienced an increase in tuberculosis in 1975.—Marianne B. McEuen, M.D., Acting Chief, Bureau of Tuberculosis Control, Jacksonville.

Rabies Book Available from Health Office

The Florida Health Program Office has published a monograph entitled "Rabies in Florida—History, Status, Trends."

The Office said the publication is a valuable desk reference, especially for pediatricians and emergency room physicians.

Copies may be obtained without charge by contacting Juan A. Tomas, D.V.M., Administrator, Veterinary Public Health Section, Health Program Office, P. O. Box 210, Jacksonville, Fla. 32201.

Seminar on Tuberculosis and the Community Hospital
A Synopsis

Joel L. Nitzkin, M.D., M.P.H. and John Q. Cleveland Jr., M.D., M.P.H.

In 1845, 40% to 50% of the population of England was infected with tuberculosis; up to 40% died. Specialized "sanitoriums" flourished where the patients with tuberculosis were "treated" for years at a time. Since then many therapies have been devised. Lungs were collapsed, lungs were removed, oil and celluloid were put in the chest.

It was not until the development of chemotherapeutic agents that truly effective therapy evolved. From the 1950s on, more and more drugs were found effective. Today there are 11 "chemotherapeutic" drugs in the tuberculosis "armamentarium."

TB Phobia

The major barriers to effective management of TB patients today are emotional, not medical in nature. Most of the general population, including many physicians and nurses, still think of tuberculosis as an untreatable disease requiring years of incarceration in a special tuberculosis hospital outside the mainstream of medical care. Not true! Modern chemotherapy now makes tuberculosis one of the most readily treatable of the chronic pulmonary disorders. Most cooperative patients, otherwise in good health, can be managed on an outpatient basis without a single day of hospitalization. Most others need not be hospitalized more than a few weeks.

A second common misconception relates to the transmissibility of tuberculosis. TB is infectious only by a respiratory route and requires a respiratory portal of entry. Thus, the droplets and droplet nuclei expelled by an infectious TB patient must be inhaled by a susceptible victim for transmission to occur. Droplets which land on walls, books, dishes, etc., present virtually no health hazard. Most of the danger can be eliminated by simply asking the cooperative patient to speak softly and cover his mouth when he coughs.

Tuberculosis — 1975

Effective drug use has obviated the necessity of hospitalizing many TB patients. In this day only two types of patients with TB require hospitalization.

1. Those with other medical problems or who have difficulty adhering to a medical program;
2. Those who are irresponsible, will not take their medication, or have other disabling social problems.

The three factors most important in influencing response to treatment are chemotherapy, sensitivity of the organism and cooperation of the patient. If chemotherapy is properly instituted, 95% of patients will be noninfectious in a few weeks and culture negative in six months if antibiotic therapy is continued. Those least likely to respond within these time limits are alcoholics previously partially treated and those with chronic cavitary disease.

Most agree that when a TB patient has a negative smear and is not coughing, he is noninfectious. Many believe that after two weeks of therapy a patient is probably noninfectious even though the smear remains positive. In one study, after therapy was instituted in 21 patients for two weeks, 107 new contacts were skin tested. None showed a skin test conversion.

General Hospital Management of the TB Patient

Each hospital needs a specific plan to meet its needs. From an administrative viewpoint, TB should be viewed as one of a group of infectious respiratory diseases. The hospital should have an educational program for both professional and nonprofessional staff and an active infectious disease control program including periodic employee TB skin testing.

The infectious TB patient should be placed in a private room with outside exhaust ventilation and, preferably, UV lights. M. tuberculosis has been

transmitted via air-conditioning ductwork from one part of a hospital to another. The requirement for outside exhaust ventilation is therefore much more important for tuberculosis than most other respiratory diseases.

The decision to release a TB patient from respiratory isolation should consider the patient's clinical condition, anticipated cooperation and personal hygiene, volume and severity of coughing and number of acid-fast organisms on smear. To be considered noninfectious the cough should be almost entirely eliminated and the chart should show a decreasing concentration of acid-fast organisms on sputum smear. As an extra precaution it would be wise to avoid placing such TB patients in a room with patients on steroids or otherwise at extremely high risk of tuberculosis immediately following release from respiratory isolation.

The most serious problem is a patient admitted to a hospital for another disorder and then found to have infectious tuberculosis. To properly deal with these patients hospital employees and administrators should understand how tuberculosis can and cannot be transmitted even if the hospital has no intention of admitting TB patients.

All community general hospitals should screen employees with direct patient contact on employment, separation and at least annually while employed. The initial and final screenings should consist of TB skin test and x-ray, with interim screenings a skin test only. This will assure the employee that even if he is exposed to infectious TB from an unrecognized case his exposure will be detected early and dealt with promptly.

Community Management of TB

Discharge planning of outpatient care should commence while the patient is in the hospital. The key issue is "Who will be in charge?" A great many people may be involved. Where will patient get his medicine and who will do his follow-up are important considerations. Before discharge, the physician must take the time to answer the patients' questions.

The most important consideration in adapting a community hospital to successfully house TB patients is education of the staff.

Conclusions

Any community hospital should be willing and able to admit and care for the patient with tuberculosis. Any community hospital should be able to cope with a patient admitted with another disorder and later found to have active infectious pulmonary tuberculosis. The major barrier to optimal management of the TB patient is "TB phobia," an irrational fear of TB totally inconsistent with current understanding of this readily treatable, moderately communicable chronic disease.

Attendance

The Seminar held May 6, 1975, was attended by 174 persons representing 39 hospitals and 18 nonhospital institutions in four South Florida counties. Of those attending there were 91 nurses, 16 physicians and 67 others. Of the others 49 failed to specify occupation. The 18 others included hospital administrators, sanitarians, an aide, technicians, and "inservice director," a therapist and several social workers.

The nonhospital institutions represented were three county health departments, three schools and universities, three lung associations, two visiting nurses associations and five miscellaneous.

Evaluation

To evaluate the impact of the seminar a one-question questionnaire was mailed out to attendees six weeks after the seminar. Of the 174 in attendance, 69 or 39.6% returned the form. The question was "Have changes in policy or procedure taken place in your hospital as a result of the May 6 Seminar?" The respondent could check "No change," "Yes, changes have been made" and add remarks.

Fifty-three of the respondents represented 28 hospitals from three of the four counties in attendance. Specific changes in policy and/or procedure were enumerated for 16 (57%) of the hospitals. Included were changes in inservice training programming (13 hospitals), isolation procedures (7 hospitals), employee health (4 hospitals), environmental services (4 hospitals), admission policies (3 hospitals) and a general liberalization in the management of tuberculosis suspects.

Of the 12 hospitals with "no change," six had recent changes in policy along the lines specified in the seminar and two had recommendations pending action before the infections control committee and/or hospital administration. No information was available on the other four hospitals with a "no change" response.

Sixteen replies were received from nine nonhospital facilities and a physician in private practice. The physician reported a change in the "entire management" of his TB patients. Two health departments reported new inservice training, as did one

visiting nurse association. One health department reported a change in skin test policies and procedure. One student health service reported "revised policies pending approval." A postal service health clinic, one health department and a nursing home reported "no change."

Faculty participants included Augusto Fernandez-Conde, M.D., Coordinator, Tuberculosis Program, Dade County Department of Public Health, Miami; Donald M. Cook, Executive Director, South Miami Hospital, South Miami; Kathleen M. DeLuca, R.N., Infection Control Nurse, Hollywood Memorial Hospital, Hollywood; N. Joel Ehrenkranz, M.D., Chief, Department of Medicine, Cedars of Lebanon Health Care Center, Miami; N. Ralph Frankel, M.D., President, Dade-Monroe Lung Association, Miami; Allan L. Goldman, M.D., Chief, Pulmonary Disease Section, Veterans Administration Hospital, Tampa; James Kieran, M.D., Chairman, Joint Committee on Professional Standards Review, American College of Chest Physicians, Berkeley, Calif.; Lawrence C. Manni, M.D., Chief, Bureau of Tuberculosis Control, Florida State Division of Health, Jacksonville; Asher Marks, M.D., Consultant in Pulmonary Disease, Veterans Administration Hospital, Miami; Margaret J. Nichols, R.N., Tuberculosis Nursing Supervisor, Dade County Department of Public Health, Miami; Joel L. Nitzkin, M.D., M.P.H., Chief, Office of Consumer Protection, Dade County Department of Public Health, Miami; Charles F. Tate Jr., M.D., Chief, Pulmonary Disease Division, Jackson Memorial Hospital, Miami, and Phyllis Upson, R.N., Program Development, Florida Lung Association, Jacksonville.

▶ Dr. Nitzkin, Dade County Department of Public Health, 1350 N. W. Fourteen Street, Miami 33125.

Editorial Comment

Education in this area is important and must reach every practicing physician who may become responsible for the treatment of tuberculosis. The seminar in itself was a good review of "what's new" on the topic. This paper is a good summary of what was said and should carry basic information to many Florida physicians, as well as stimulate others to learn more.—N. Ralph Frankel, M.D., North Miami.

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*First Health and Nutrition Examination Survey, DHEW Pub. No. (HRA) 74-1219-1, National Center for Health Statistics, Rockville, Maryland. (This report indicates that approximately 95% of the children 1-5 years old had iron intakes *below* the standard set by the Food and Nutrition Board of the National Academy of Sciences.)

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1. For the relief of symptoms associated with cerebral vascular insufficiency.
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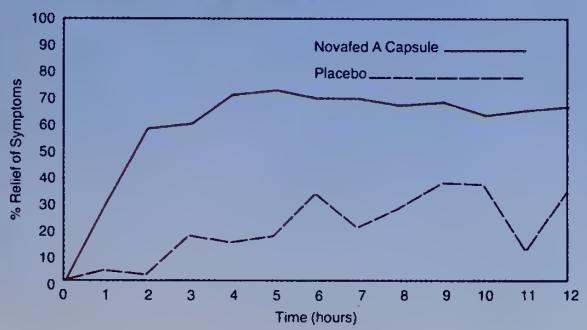
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(Please refer to the following page for bioavailability studies and prescribing information.)



Patients with severe pollen allergies were tested during hay fever season in a countryside environment and asked to rate severity of five different symptoms on a scale of 1 to 4.

Clinical Study: Degree of Relief from Itchy Eyes and Nose and Throat, Watery Eyes, Runny Nose*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

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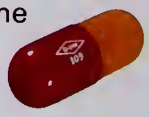
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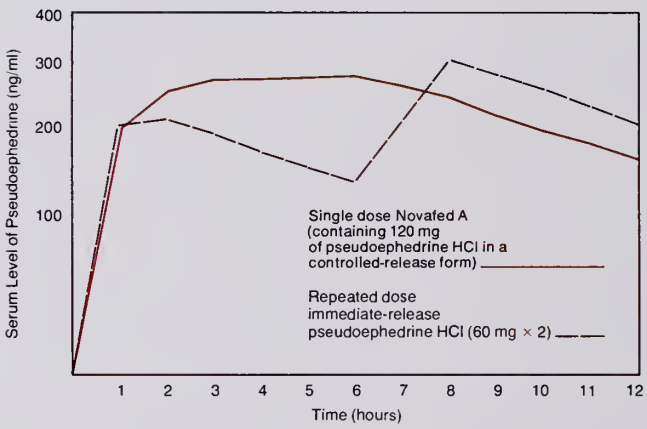
Prompt onset and sustained serum levels over 12 hours

A bioavailability study confirmed that the sustained 12-hour action of Novafed A was comparable to that of immediate-release medication taken at 6-hour intervals.

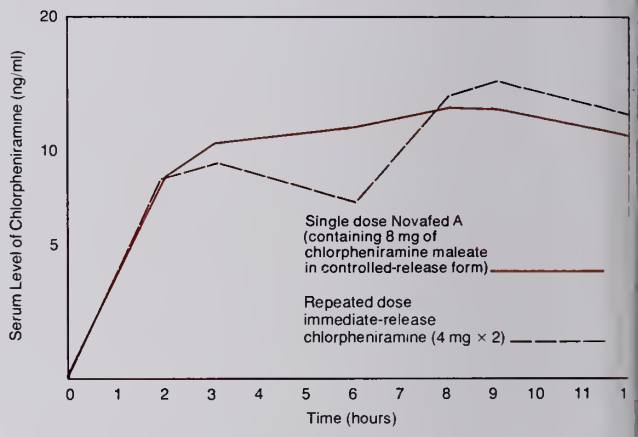
The chart at the left shows the serum levels of pseudoephedrine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 60 mg. pseudoephedrine hydrochloride in an immediate-release form. Serum levels of pseudoephedrine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

The chart at the right shows the serum levels of chlorpheniramine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 4 mg. chlorpheniramine maleate in an immediate-release form. Serum levels of chlorpheniramine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

Comparison of Mean Serum Levels of Pseudoephedrine Following Novafed A and an Immediate-Release Reference Formulation*



Comparison of Mean Serum Levels of Chlorpheniramine Following Novafed A and an Immediate-Release Reference Formulation*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DESCRIPTION: Each NOVAFED A capsule contains 120 mg. of pseudoephedrine hydrochloride and 8 mg. of chlorpheniramine maleate. The specially formulated pellets in each capsule are designed to provide continuous therapeutic effect for about 12 hours. Nearly one-half of the active ingredients is released soon after administration and the remainder is released slowly over the remaining time period.

ACTIONS: NOVAFEO A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

INDICATIONS: NOVAFEO A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Oecongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFEO A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIONS: Symphathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFEO A controlled-release capsules should not be used in children less than 12 years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension or in patients with a history of bronchial asthma.

Oo not exceed recommended dosage.

Use in Pregnancy: The safety of pseudoephedrine for use during pregnancy has not been established.

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reaction to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CN depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIONS: MAO inhibitors and beta adrenergi blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcoho tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

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SPECIAL ARTICLES

A Look at the "Baker Act"

Philip B. Phillips, M.D. and Roswitha B. Fischer, M.A.

Abstract: When the Florida legislature passed the "Baker Act" in 1972 it initiated an important new program wherein the state accepted financial responsibility for the private care of indigent psychiatric patients. Local general hospitals are paid for up to fifteen days of care and privately practicing psychiatrists may accept and treat such patients at state expense, on a stipulated fee schedule.

Experience has shown that there are a number of good things about this new approach and still a number of serious deficiencies which may require further legislative correction.

This short article highlights some of the experiences in Northwest Florida. Family physicians and other specialists will see that government subsidy brings limitations and regulations that are not always medically in the patients' best interest but perhaps are at least a step or two ahead of previous conditions. Constant vigilance on the part of physicians is essential to assure that these funded programs not only make care available but that this care is reasonable, necessary, appropriate and of high professional quality.

In July 1972, the Florida Mental Health Act or "Baker Act" was passed by the state legislature to provide, among other things, inpatient care in local general or psychiatric hospitals for indigent psychiatric patients by either private psychiatrists or Mental Health Center staff. This law permits psychiatrists to treat patients for a maximum of 15 days before release or transfer to a state hospital. Reluctant patients may be detained involuntarily up to five days for careful evaluation by two psychiatrists. The civil rights of all patients are protected. Involuntary patients are assured of a hearing before a judge, and may request an attorney to represent them. The necessity of their local inhospital treatment and possible transfer to a state hospital is legally established by a Circuit Court judge. Involuntarily detained patients may change to voluntary status if they willingly accept treatment. The law also establishes the right of a patient confined in a state hospital to have his case reviewed before a hearings examiner at six month intervals to determine the need for further treatment. Under provisions of the Baker Act the local hospital is paid its daily rate, and the attending psychiatrist a specified but modest fee by the District Mental Health Board, a local agency under supervision of the State Department of Health and Rehabilitative Services.

The various states have for years provided long-term inpatient treatment in state supported hospitals. Recently mushrooming Mental Health Centers have provided a form of outpatient care to all who sought help regardless of their financial status. This unwarranted intrusion into the field of private practice by tax and grant supported agencies will not be elaborated on at this point. Florida was one of the earlier states in the underwriting of private limited care of the indigent psychiatric patient in a community hospital. Texas, a number of years ago, under the Ruilman plan, paid private psychiatrists to treat indigents locally as was deemed necessary and authorized them to send the State Mental Health Director the bill for their services.

Several developments occurred in Florida with this very generous "Baker Act" legislation. As public knowledge of the Act grew, there was an increasing demand from the indigent neurotic to be admitted to the hospital for a few days primarily to "rest up," to get away from an unhappy marriage, irritating children or nagging in-laws. Many indigent parents felt that their ill-behaving children needed psychiatric care and that "the growing-up behavior patterns" of adolescents merited hospitalization. Conscientious psychiatrists were reluctant to admit patients for expensive but unnecessary hospitalization, but costs for these services still increased, and were examined by the legislature which revised the law, defining specifically which disorders "Baker Act" funds would cover.

(a) Patients with character and behavior disorders are denied hospitalization and medical care under the Baker Act. Such a diagnosis leaves the hospital and the psychiatrist uncompensated. (There is a rumor that the incidence of these maladies, or at least these diagnoses, is decreasing in Florida.)

(b) Electroshock therapy was not approved although it could be effective in depressions and avoid some patients' transfer to a state hospital.

(c) Alcoholics with or without delirium tremens were held to be not psychiatric problems, but most experienced and conservative psychiatrists consider delirium a medical psychiatric emergency. This administrative decision was apparently a financial rather than a medical one made when the State Alcoholic Rehabilitation Program had money left over and all the "Baker Act" money had been spent (too much of it, the Director thought, on alcoholics). Hence, alcoholics in any form were not considered to be psychiatric problems—perhaps a good decision based on faulty reasoning.

The Baker Act is a reflection of great interest on the part of a number of legislators in providing better care for the psychiatric patient. The Medicare program for the elderly and the totally disabled already existed as did Medicaid with its tight limitations providing necessary inpatient care for welfare recipients who required it. Any of these programs financed by a third party—federal, state or local government —demand a high degree of professional judgment and integrity if taxpayers' funds are to be spent wisely for those who need care and not wasted on those who do not.

What are the experiences of the first few years? During the 1974-75 fiscal year, 13,730 psychiatric patients were admitted to local hospitals under the aegis of the Baker Act. Most of these patients were indigents. The average hospital stay was eight days per patient. The state paid the hospitals an average of $65.25 per day per patient and $611.44 per patient per admission. This was only 75% of the total cost, the remainder being paid by the local governments.

To illustrate: In the Pensacola area, 276 indigent patients were admitted to the local hospitals during the 1974-75 fiscal year. The average stay was seven days per patient at a cost of $78.73 per patient day. The cost per admission was $551.11. Of the 276 patients 107 had to be transferred to the state hospital for further care which averaged three months. The cost per patient per day in the state hospital was $26.40.

When the psychiatrists reviewed costs it was apparent that keeping a chronic psychotic patient in the community hospital was not economical so efforts were made to expedite the transfer of those patients to the state hospital when the need for long-term care was determined. The Circuit Judge dealing with these patients is very cooperative and comes to the hospital once a week to hear the psychiatrists testimony on their involuntary patients. Recommendations by the doctor might be for a longer stay in the local hospital (up to the 15 day limit) or for prompt transfer to the state hospital.

There seemed to be several advantages and disadvantages in the Baker Act as one would expect from any legislation. Among the advantages are:

(a) The patient has a right to receive proper and adequate treatment no matter what his financial standing.

(b) He may be treated in a local hospital near his home where he can be visited by his relatives.

(c) Families of a patient have the right to arrange for his involuntary detention and treatment if the doctors and judge agree that it is necessary.

(d) The patient has the right of access to legal counsel.

Some of the disadvantages seem to be that:

(a) The patient confined to the state hospital has the right to refuse treatment when his condition has begun to improve and his judgment is considered acceptable. It is not clear who should make this determination as to his judgment.

(b) The decision of the Supreme Court in 1975 that committed mental patients who are not dangerous and can live safely outside an institution cannot be confined without treatment seems ambiguous and leaves the psychiatrist to make this decision.

(c) The patient may, if he chooses, sue the physician or hospital for fancied malpractice.

(d) A patient is, in fact, assured of so many rights that a litigious paranoid can almost require the psychiatrist to seek legal help himself. Although a psychotic patient may be treated with medication and restraint if the psychiatrist believes that such is necessary whether the patient concurs or not, once the patient's psychosis is even in partial remission he may refuse treatment and thus prolong his hospitalization. In doing so he costs the state much more money than he would if he accepted treatment as offered. It seems that "treatment" has to be defined clearly by psychiatrists and legislators if hospital stays are to be shortened and outpatient treatment initiated once the psychosis is in remission. Whether milieu therapy in a protected environment is a form of treatment must also be decided.

Patients who have made suicidal gestures and attempts or exhibit deviant behavior patterns and character disorders require a minimum three days of observation by the psychiatrist and the nursing staff. Payments should be authorized for the hospital and physician during this evaluation period.

The recently approved "primary care centers" for alcoholics are merely drying out centers for the person with simple drunkenness not refusing treatment or having a need for hospital care. This is a desirable change from jail detention of the "drunk", but alcoholics with impending D.T.'s should be recognized as psychiatric patients and be provided with hospitalization.

Electroshock therapy for selected patients should be permitted. The treating psychiatrist should be permitted to document the necessity of a seven day extension of the period of local hospitalization when it can reduce the number of patients who have to be sent to the state hospital where many will remain only a few weeks longer in treatment.

There is currently no means of assuring that the treated and released inpatient whose psychosis is in remission will continue treatment visits or continue medication. Since statistics show that eight out of ten admissions are really readmissions (often treatment fails, due to medicine not being taken) some method must be devised to get released patients to continue their medication and outpatient clinic visits.

The increased use of depot neuroleptics the past ten years has shown promise as a method of controlling psychosis. But, in the areas of the state with inadequate transportation facilities it is easy for the reluctant, released, partially-recovered patient to refuse further care. What then is the public's responsibility in this? Infectious tubercular or venereal patients may be required to accept treatment. Does the public have a right to force a psychotic patient to accept a reasonable form of current therapy in order to remain free of psychosis, to require his attendance at a Center where he will receive injections of long-acting neuroleptics, or to insist that he continue his oral antipsychotic agents, and contact with his psychiatrist?

Although the average psychotic patient is less a danger to the public than an alcoholic or drug abuser there seems to be a higher right of society to require the psychotic patient to continue treatment especially when public monies are being expended in his total care. The cost of recurring hospital admissions of patients who refuse to continue outpatient treatment or who are too ignorant to do so is significant. Shall the mental patient be able to exercise a "right" to drain the pocketbook of the taxpayer or shall an enlightened public have the "right" to insist that the psychotic patient continue treatment which reasonably assures him of continuing mental health?

▶ Dr. Phillips, 1515 West Moreno Street, Pensacola 32501.

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Case Report

Sneeze Neuropathy by Allan Herskowitz, M.D., Paul Fass, M.D., and Marshall Abel, M.D.

Recently we had the opportunity to investigate an interesting patient with an unusual complaint.

The patient, a 36-year-old man, had been in excellent health until one month previously when he began noticing paresthesias over the right maxillary area within one to two minutes after sneezing or blowing his nose. This sensation would last approximately five minutes and be followed by a right retro-orbital throbbing pain which would be present for another 15-20 minutes.

Upon examination immediately after symptoms occurred, there was hypesthesia to pinprick in the V1 and V2 distribution on the right and a decreased corneal reflex. This reverted to normal as he symptomatically felt better. X-rays showed a smooth density approximately 2 cm in diameter in the right maxillary sinus along the posteromedial wall. The remainder of the neurologic workup including skull x-rays, brain scan and electroencephalogram revealed no abnormalities.

Surgery was performed with complete extirpation of the mass. The pathologic diagnosis was mucocele. Postsurgically, for the past seven months, the patient has been totally asymptomatic.

It is difficult to completely explain neuroanatomically the relationship of the lesion to the symptoms. It is quite clear that it was the cause of his symptoms since he has been asymptomatic since the mucocele was removed. One plausible explanation for the paresthesias and numbness over the V2 distribution is that as he sneezed or blew his nose the mass expanded, thus compressing some of the cutaneous or more superficial branches of the maxillary division of the trigeminal nerve. What is difficult to explain on a local basis is the impaired corneal reflex. Possibly if the patient had platybasia, increased pressure by sneezing could have somehow caused transitory compression of the descending tract of V. Cervical spine x-rays, however, did not reveal these findings. The right retro-orbital headaches, of course, may well be related to referred pain from the right maxillary sinus.

We believe that this is an unusual cause of a compressive neuropathy and merits mention. It at least ranks with the most recently reported compressive neuropathies, i.e., shopping bag neuropathy, handle-bar neuropathy, toilet seat neuropathy, and ski boot neuropathy. It is beginning to appear that nerves of the body have no safe places to hide.

References

1. Kopell, H. and Thompson, W.: Peripheral Entrapment Neuropathies. Williams and Wilkins Company, Baltimore, 1963.
2. Haymaker, W. and Woodhal, B.: Peripheral Nerve Injuries, Second Edition, W. B. Saunders Company, Philadelphia, 1953.
3. Medical Research Counsel: Aids to Investigation of Peripheral Nerve Injuries, Second Edition. British Information Services, New York, 1958.
4. Stookey, B.: Surgical and Mechanical Treatment of Peripheral Nerves, W. B. Saunders Company, Philadelphia, 1922.
5. Sunderland, S.: Nerve and Nerve Injuries, Williams and Wilkins Company, Baltimore, 1968.

▶ Dr. Herskowitz, 155 Northwest 167 Street, North Miami Beach 33169.

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EDITORIAL

The Physician Legislator

The cover of the April issue highlights Florida's physician legislators—Senator David C. Lane and Representatives Richard S. Hodes, David J. Lehman Jr., and Walter W. Sackett Jr.

State Legislators are particularly concerned with education and health and rehabilitative services—as these in aggregate consume about 80% of the State's general revenue tax dollars. As such, it is of vital import that the physicians of Florida recognize the role of the State's legislature in almost every facet of education and health. Thus, physician legislators have an opportunity to be particularly effective in drafting, promulgating, implementing, and monitoring health legislation.

Though the Federal Government, through the Department of HEW, still plays a transcendent role in many health services, the concept of block grants to the states will allow increasing flexibility in the expenditure of such dollars by state legislators. Rules and regulations vary from state to state, so that the role of the legislator assumes greater significance in the wise and creative use of these funds.

The Tallahassee scene—a cauldron of activity including many special interests—almost daily attests to the unusual effectiveness of our physician legislators. Their influence far outweighs their number.

Legislative service has many personal compensations to justify the time away from medical practice. The physician legislator enjoys added status and prestige, the ego boost of public exposure, attention from the media and a constant stream of individuals asking help. Whether this be for support of a particular issue, or aid in the solution of a particular problem—one that often involves unraveling the maze of the State's bureaucracy—the judgment and service role in which the physician legislator finds himself can be immensely satisfying.

Much less publicized, and often overlooked, are the many impingements and encroachments on the private life of a physician who also serves as a legislator. A genuine sacrifice is involved in being away from home and family for many months each year, including heavy financial losses that place great stress on all involved. Although the legislature is officially in session for only two months, recent experience shows a tendency to require the active involvement of legislators for a much longer time—even up to nine months per year. The average citizen harbors the concept that his representative is "on call" 24 hours per day through every day of the year. Constant badgering and harassment by individuals who feel impelled to share their views with him, means inability to enjoy social events. If he is a new legislator he may be relatively ineffective until he has devoted much time to learning the "rules of the game." Frequently, an individual has to spend many years as a legislator before he receives a coveted committee assignment and still longer before he becomes chairman of a committee or subcommittee. During this period, he must adjust to the ebb and flow of changing leadership within each branch of the legislature. He must recognize that there are penalties as well as rewards associated with challenging the Speaker of the House or the President of the Senate. He must learn to use tactics of compromise to achieve goals without compromising his own standard of ethics and fair play. And finally, he must maintain a viable relationship with associates in practice in his home town.

If the physician legislator is in practice by himself, then appropriate arrangements must be made with colleagues to cover adequately the needs of his patients. When he has partners, such partners indirectly contribute to the overall legislative thrust of Florida's physicians. By maintaining a comfortable home environment for the physician legislator, his partners enable him to be productive on the Tallahassee scene.

Stresses and strains are inevitable in any responsible human relationship, as a group of physicians in practice. When one member enters the legislature, the stresses are intensified. They may develop a comfortable modus vivendi—with the phy-

sician legislator making the suitable arrangements with his partners to compensate them for the time they spend caring for his patients while he is in Tallahassee. On the other hand, the partners may eventually deliver an ultimatum to the effect that the physician legislator must either choose to remain a partner or pursue his role in the legislature, but not both.

Thus, the joys and plights of our physician legislators. By some modality, we must encourage more physicians to seek public office, enter the legislative forum, and then make it possible for them to remain in the legislature long enough to garner legislative strength. Think of the effectiveness of our present four! Think also of the sad state of our legislative thrust if we had **no** physicians in the Florida legislature.

Consider the position of our professional counterparts, the lawyers: 1) they have traditionally sought public office, so that 25-60% of each House may at any time be composed of lawyers; 2) their training is better designed to adapt to the legislative process; 3) laws promulgated by them will affect individuals who will be prosecuted or defended by them or their colleagues; 4) laws, when appealed, will be interpreted finally by lawyers sitting as judges on some court; and 5) the final governing body of the legal profession in Florida is the State Supreme Court—the members of which are all lawyers—with that body being a co-equal with the legislative and executive branch in State government.

Should not the physicians be entitled to a parallel structure, with our State Board of Medical Examiners being tantamount to our Supreme Court on medical matters, or should we petition to have physicians placed on the Supreme Court itself?

Until that happy day, each of us must rely on our four stalwart physician legislators. The Editors of the Journal salute and thank each of them at the beginning of this legislative session.

THE EDITOR

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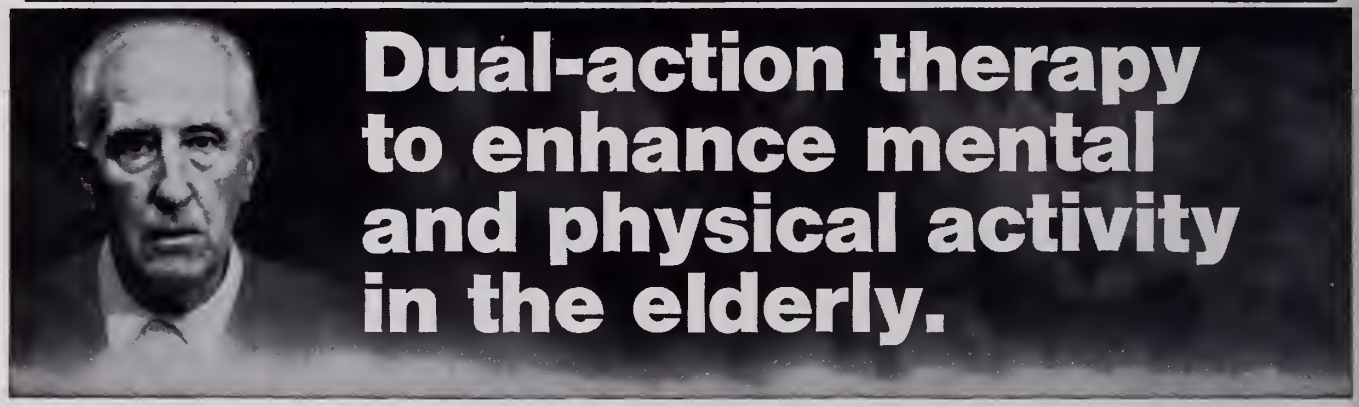
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ORGANIZATION

They Will be There

When the 1976 Legislature convenes this month, four Florida physicians with long, distinguished records of sevice to their State and their profession will take their seats in the midst of a group consisting primarily of attorneys, businessmen, farmers and blue-collar workers.

Together, they have 27 years of legislative service. Individually, they are respected professionals who have spoken expertly and convincingly for Medicine in the legislative chambers without compromising their duty to their constituency. They are:

— State Sen. David C. Lane, M.D., of Ft. Lauderdale, neurosurgeon and Republican, has represented the 31st Senatorial District since his election in 1967.

— Rep. Richard S. Hodes, M.D., of Tampa, is an anesthesiologist. He has been a Democratic representative from Hillsborough County since 1966.

— Rep. Walter W. Sackett Jr., M.D., has represented Dade County's 110th District as a Democrat since 1966. He is a family practitioner.

— Rep. David J. Lehman, M.D., of Hollywood, is the junior member of the physician contingent in the Legislature. An internist, he was elected as a Democrat to represent the 97th District in 1974.

Like so many other Floridians all four physician-legislators were born elsewhere, all in fact, in the northeastern United States. Senator Lane was born in Massachusetts. Representative Sackett hails from Connecticut, while Representatives Hodes and Lehman are natives of New York and New Jersey, respectively.

Drs. Lane and Hodes have served in the leadership of their respective chambers, Dr. Lane as Senate Minority Leader, and Dr. Hodes as Chairman of the House Health and Rehabilitative Services and Education Committees.

One of the Association's highest honors, the Certificate of Appreciation, was bestowed on Dr. Lane in 1972. Dr. Hodes, Treasurer of FMA, received the A. H. Robins Award for Community Service by a Physician at the 101st Annual Meeting last year.

Dr. Sackett is known nationally as an advocate of "death with dignity" legislation, a subject he has discussed many times on network television.

For many years, Dr. Lehman has had a special interest in drug abuse. He has served in many capacities in that area, including the Chairman of the FMA Committee on Drug Abuse.

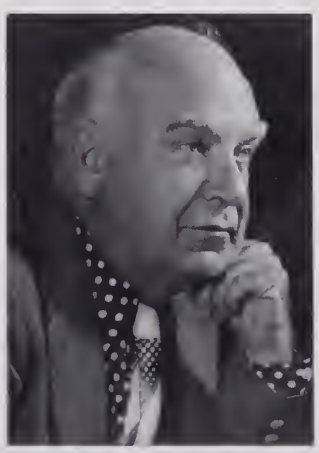
All four men have made great professional and personal sacrifices to serve their fellow citizens. They deserve the plaudits of all Floridians.



Dr. Lane



Dr. Hodes



Dr. Sackett



Dr. Lehman

Commentary

PLI Up-Date

Strong, forthright action to solve the professional liability insurance crisis is being considered by the 1976 session of the Florida Legislature. The Legislature is being urged to act on a meaningful, constructive and bold program presented by the Florida Medical Association.

As one source termed the FMA suggestions, "We have put it on the line . . . these are basic, practical and positive answers to the problem. They represent hard work, study and a real desire to see this crisis through to a prompt, meaningful solution. We know this program will work and will succeed if enacted into law!"

The FMA program comes at the right time! In fact, timely, effective and commonsense action is needed to head off the threat which this crisis poses to the continuance of top flight, quality health care in Florida.

FMA President, Vernon B. Astler of Delray Beach, puts it forcefully, "Enough is enough! Our people know their health care is being threatened by a situation over which their physician no longer has control. Yet they've turned to us for answers . . . recognizing the commitment of every physician to high quality, personal health care. We've done our homework, our study and brought forth significant answers. Now it's in the hands of our state government to guarantee that the basic desire of every family for health and medical care and service is not destroyed by the action of a few taking advantage of a legal system in desperate need of reform!"

The FMA suggestions are based as Dr. Astler indicates on extensive study over the last decade by Florida's medical leadership. The five comprehensive bills submitted to the Legislature are a result of FMA research and particular effort in the last year. They provide a way out of the present crisis and will be of great advantage in curtailing the spiraling costs caused by the frequency of claims, the increased amounts for damages awarded and the defense of unwarranted suits.

PERSON TO PERSON CONTACT

In March, virtually every member of the State Legislature was personally visited to encourage awareness of the problem facing Florida citizens in the health and medical care area. Legislators were urged to support the positive action proposed by the FMA to solve this problem created by the PLI rate increase. One goal of these meetings was to remind each legislator of the widespread regard the average Florida citizen has for the quality of health care in our State. To continue such quality, we must end the threat posed to our system through the ever-escalating prices caused by high award damages and insurance rate increases.

In December, 1975, a statewide public opinion survey commissioned by FMA revealed that the overwhelming majority of Floridians, as represented in the poll, have great confidence in the services provided by physicians and in the quality of the health care the people enjoy. Those responding, moreover, expressed their belief that the malpractice insurance issue was a threat to quality health care, could cause a breakdown in the doctor-patient relation regarded as vital, and discourages the continued advance of medical science and care.

In the personal conferences, Florida legislators were presented a twenty page resource document which reviewed the PLI crisis and gave indepth information in support of the FMA legislative recommendations.

Conducting these meetings, which were coordinated through county medical societies, were key

legislative contact members from each county and a member of the FMA staff and/or legislative legal counsel. The thrust of the meetings was informational, providing documentary material and backup evidence to undergird the forward-looking proposals suggested by FMA to stop the PLI crisis.

INITIAL RESPONSE FAVORABLE

Initial response indicates the members of the Legislature appreciate the care, research, and study which have gone into the FMA program. They indicated that Florida legislators want to head off the crisis and soften its effects on the average Florida family. There is awareness that the malpractice insurance crisis increases health care costs and jeopardizes high quality health care.

Many Floridians also recognize that the medical professional liability issue is only the start. Every profession faces a similar crisis and the sound, fair procedure established as a result of our outcome can and will affect the future of life in our state.

Key contact members and FMA staffers reviewed with legislators the fact that the PLI situation is causing Florida to lose doctors, is reducing the practice of certain areas of high risk medicine, and is generating a cost crunch that could be literally catastrophic for Floridians.

Because the malpractice issue is very present in the public mind, (a recent Gallup Poll showed that one out of every ten Americans were aware of its impact), legislators were urged to give immediate priority to the creative plan suggested by the FMA. The basic foundation of the plan is a call for much-needed legal reform in our system of tort reparations or personal injury awards.

ACTION NOW!

The time for action is **now**. The programs suggested to the State Legislature are ones which Florida physicians can view with pride, confidence and heartily support toward enactment.

Every member of the FMA is urged to write his or her State Senator or Representative in care of the Capitol Building, Tallahassee, 32301. Ask that serious, indepth and personal consideration be given to the program offered by Florida medicine to solve, in a meaningful way, the PLI crisis. Every member of Florida medicine, moreover, is urged to let patients as well as friends and neighbors know that organized medicine is continuing to meet the public need and is acting in a trustworthy fashion to halt one problem which poses a threat to the wellbeing of our citizens.

1976 is the year for decision in Florida and decisions start with the will of the people as expressed through their elected representatives in Tallahassee. Florida medicine through a public information drive, based on the study and research expected of the medical community, is striving to end the jeopardy in which the delivery of medical care in this state has been placed by escalated professional liability insurance costs.

We are confident that the Legislature will give this program the consideration it deserves. We realistically anticipate positive action. We know the Legislature recognizes both the public's concern in this issue and its ultimate wellbeing . . . and, in so doing will respond to the FMA program. Such action will serve the best interest of the people of Florida, an interest to which every physician has dedicated his or her professional service.

The Editor

TRUE SUCCESS

To laugh often and much; to win the respect of intelligent people and the affection of children; to earn the appreciation of honest critics and endure the betrayal of false friends; to appreciate beauty; to find the best in others; to leave the world a bit better whether by a healthy child, a garden patch, or a redeemed social condition; to know even one life has breathed easier because you lived. This is to have succeeded. —Ralph Waldo Emerson



Others Are Saying

The Medical Commons

It may well be that the problem of the ever increasing cost of medical care in the United States has no solution, or so Howard Hiatt suggested in a recent publication.[1] He contends that our total resources are analogous to the common field used by ancient herdsmen to graze their cattle. As long as the number of animals in relation to the size of the field was small each herdsman could, without any consideration, graze an increasing number of animals. As the capacity of the "commons" was reached the addition of even a single animal would effect further overgrazing. Yet, an individual herdsman would contend that the addition of just one more of his animals would have minimal effect on the general welfare.

Hiatt contends that our medical resources are indeed "a medical commons" that appears in imminent danger of being overgrazed. While it is still possible that there is considerable distance between the dollars we now spend and medical fiscal disaster, no one can hold that there is a level beyond which this nation can not spend for its health. If we are not to have an overgrazed "commons," there must be careful, prospective consideration of the way we are using it and a search for alternative approaches to its use.

First, there must be constraints put upon the introduction of medical practices and procedures that have little significant benefit or gain over those presently in use. A marginal gain at great cost is no longer "a good reason." We must determine whether individual benefit may well produce collective disaster. Consideration carried out in this manner might well lead to the conclusion that we can not justify, for example, universal screening of children for agammaglobulinemia, replication of pre-hospital rescue units in every city of a 100,000 population, or provide kidney dialysis and transplant facilities universally.

Additionally our present system in which there is essential, total freedom to the "commons" has allowed resources to be dissipated in practices and procedures that may actually be harmful to both individuals and society. Some of these have been discarded such as renal capsule stripping for hypertension, wiring of an aortic aneurysm, and total dental extraction to eradicate foci of infection. Others persist with unabated vigor despite convincing evidence that sharp curtailment or outright abandonment should be their fate. Among these are the continued use of oral hypoglycemic agents, an indiscriminate replication of diagnostic and acute care facilities, and "routine" use of antibiotics.

If our medical resources are not to be totally depleted by continued demands upon them, there must be additional, radical reeducation of both society and the profession to attend to the prevention of disease. The public must recognize that the vast epidemics of modern society — traumatic injury, heart disease, stroke, hypertension, and even cancer —could be stopped by modification of driving habits and diet, cessation of smoking, and prospective exercise programs. Eventually we will not allow the expenditure of limited resources on crisis medical care for entities preventable for a fractional cost.

Last, physicians must accept the increasing necessity for pilot projects and prospective trials before new and expensive practices and procedures are adopted. We simply must ask, "Is the value derived worth it, and can we collectively afford it?" While we should not accept the inevitability of the "medical commons" as a barren, parched bit of land, we should seriously contemplate the possibility that it can become such.

Roy H. Behnke, M.D.
Tampa

1. Hiatt H. H.: Protecting the Medical Commons: Who Is Responsible? N. England J. Med. 293:235-241, 1975.

Reprinted from The Editor's Column, The Bulletin of the Hillsborough County Medical Association, February 1976.

Man, The Vanishing Species

This editorial is presented with the knowledge that I am presenting a controversial subject. However, I feel that I am expressing what many are hesitant to put in print since it can readily be misinterpreted.

Recently a relative of mine encountered the quota system in his attempt to get into a medical school. This reminded me that I am of a minority group also and had difficulty getting into medical school in 1937. The quota system worked to keep me out of medical school, not as now, to help the minorities. All I asked then was that my qualifications be judged strictly on their merit. With the pendulum swinging in the other direction, injustices are just as rampant now as in 1937.

In this vein, many of our social problems now are directly related to the "brain trusters" who have been the hallmark of our system since the presidencies of Franklin Roosevelt. No one denies that every American deserves the rights of food, shelter, education, dental and medical care, and equal opportunity to better himself. Only a bigot, and there are still many among us, would deny equal rights for all our citizens. The only argument should be as to how these basic rights are to be provided.

If the nature series on our televisions have done nothing else they have stressed the basic nature of the survival of the species. Without fail, survival of the fittest is evident whether it be from the words of the commentator or from the actual scenes themselves. The old, the young and the physically unfit fall prey to the stronger. Nature can be cruel, but there is no other way to insure the survival of the species. History is full of animals and civilizations which have become extinct because they were not strong enough or sufficiently adaptable to survive adversity.

I am as sympathetic as anyone else to the needs of my fellow man. I believe, however, that our philosophy of life must change if our civilization is to survive. I am not convinced that we are not following the same road that led to the decline of the Roman Empire.

Rugged individualism built America and made it strong. As America grew there were many cruelties and injustices which must not be repeated. Today, nevertheless, ambition and ability are downgraded. Mediocrity is stressed, urged and supported. If there is no hope that our lawmakers will be statesmen first and politicians second, there really can be no expectation that this social erosion can be slowed or reversed.

Each year finds fewer givers and more takers. New York City is a prime example of this. Its budget now exceeds its income. If New York City does not revert back to the lessons taught by natural history, our largest city will be bankrupt. Even if New York City is temporarily strengthened by a financial transfusion from the national treasury, the results will be as hopeless as blood transfused in an ulcer case where the lesion will not stop bleeding. At that point drastic measures are mandatory or the patient will die. The fate of New York City will give an indication of what will happen to the rest of this country if there is no drastic revision of our philosophy and laws.

For New York City to survive, there must be less welfare, less waste of money, less dishonesty, less money for desirable but unessential programs and every able bodied citizen will have to work or go hungry. There is just no other way. The men in the ivory towers tell us that deficit financing leads to no insoluble problem. If it is impossible to run any private enterprise with deficit spending, how can our government justify same, despite its graphs, its concern with the gross national product and its "brain trusters?"

Some may wonder if I have strayed from my original theme. Obviously I have not. Since the same philosophy that is weakening our country has now crept into the selection of students for our medical schools, I am worried. When the theme is more doctors and not better doctors, all should be concerned. When mediocrity is stressed, when minorities are supported beyond their innate ability, and when promising applicants are shunted aside, there can be only one ultimate result: more medical care but inferior medical care. This regression in the quality of medical care may not be evident immediately but will be just as inevitable as the obvious decline of all our other social institutions.

If there is any answer to our present predicament, there must be mercy, justice and equality for all, but accomplishment must be a personal achieve-

ment based on effort, ability, ambition and the determination to succeed. Color, race, religion and political belief should be no hindrance, but on the other hand, these should not be used to abridge the rights of others. When we return to a moral but rugged individualism, there can be hope. Until we do, we are only deluding ourselves. Let's not ruin this wonderful country for our children and grandchildren and the future generations.

H. K. Moore, M.D.
Key West

Reprinted from the Florida Family Physician, Winter 1976.

American Medicine in 1776 was Simple and Primitive

Medical care in the American colonies in 1776 was a crude and primitive affair compared to today's highly developed health care system; in fact, for many Americans, there just weren't any doctors at all, and home medicine was the only answer. Most of the nation lived in remote rural areas. The crisis was over—the patient either survived or died—before the doctor could arrive on horseback, and if you did find a doctor, his knowledge, tools and medicines were scant indeed compared to today's sophisticated and scientific medicine.

The doctor probably had never attended medical school and had no license to practice medicine; he didn't really know what caused most diseases and he didn't really know how to treat them. His answer to disease in those days was likely to be to open a vein in the wrist and draw off a pint or two of blood . . . or a dose with a very strong emetic to induce vomiting . . . or a strong purgative to cleanse the bowels. Often the treatment did more harm than good. He didn't know about germs and how to prevent infection. Pasteur and Lister were still far in the future. Sometimes he had a few items to relieve pain—alcohol, opium, laudanum. He had no penicillin, no insulin, no vaccines, no anesthetics.

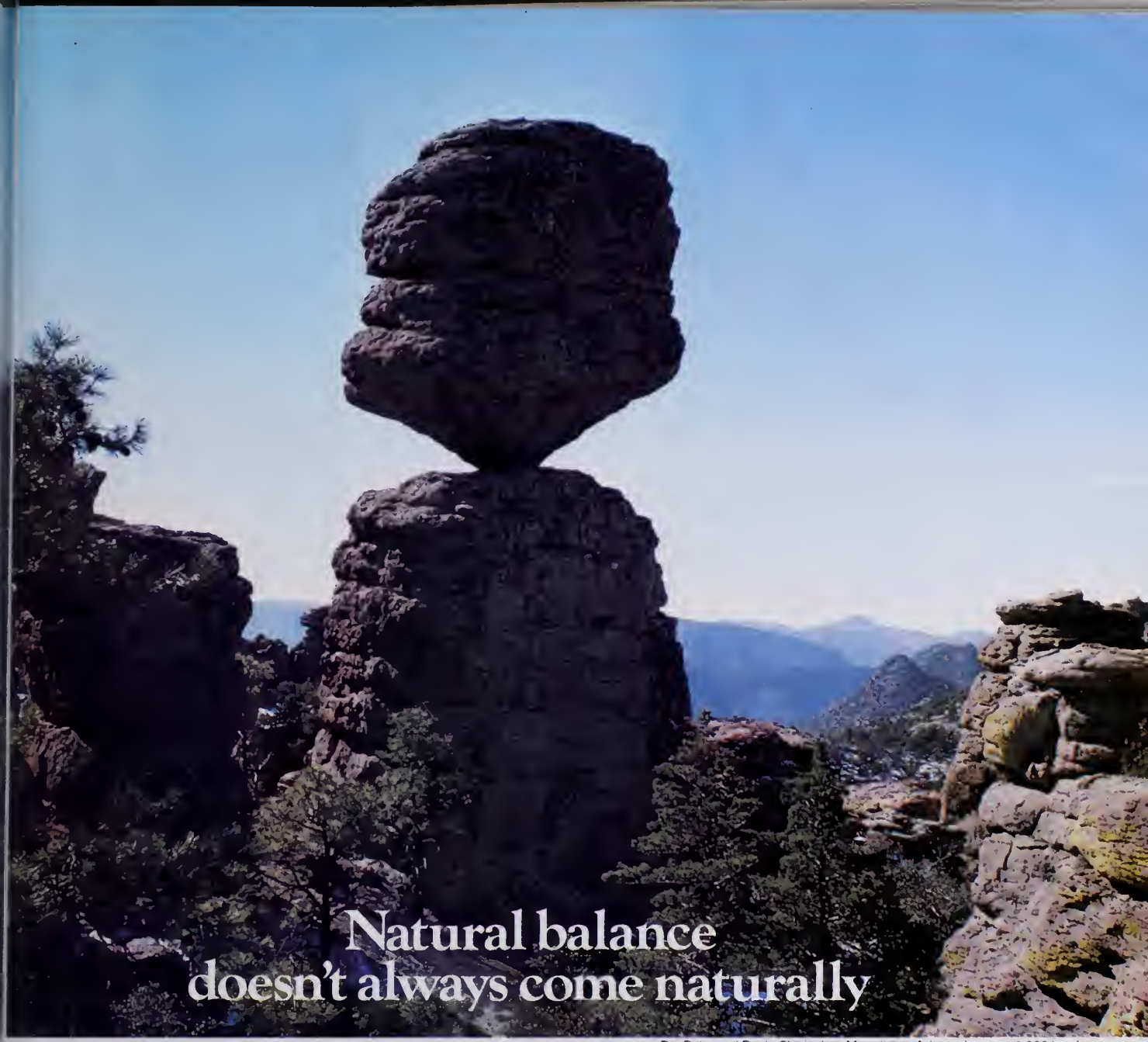
There were about as many doctors for the population two hundred years ago as there are today—one to 600. At the time of the Revolution there were around 3,500 fairly legitimate medical practitioners in the thirteen colonies. Less than four hundred of these possessed medical degrees. Most had been trained under the apprentice system. A very few were products of European medical schools, or one of the two new American schools.

In colonial times, the aspiring physician apprenticed himself to an older doctor, served several years, and received from his mentor a certificate certifying his competence to practice medicine. Surgery consisted largely of amputations of injured arms and legs. Many of the patients died of infection and loss of blood. The doctor had to get by without most of today's common medical tools — clinical thermometer, stethoscope, hypodermic syringe. Colonial physicians used a variety of drugs when they could get them, such as "Jesuit's Bark," (quinine) for fevers, and they drew heavily on the native plants and shrubs. Knowledge of therapeutic plants, gained through generations of experimentation, was considerable, and could aid in relieving pain and in curing some diseases. Fevers, smallpox and dysentery caused much of the illness. Life expectancy was short and the degenerative diseases of advancing years were a minor health problem for most Americans in 1776. Dirt and poorly cooked food and drink made dysentery a highly common health problem in the Continental Army. Influenza and pneumonia were common, thriving on poor ventilation, crowded conditions, dirt and poor diet.

Despite their handicaps, American doctors did the best they could and their very presence was a great help to many sick individuals. The doctor was a prominent man in his community. Several doctors were among the signers of the Declaration of Independence: Josiah Bartlett of New Hampshire; Lyman Hall of Georgia; Benjamin Rush of Pennsylvania; Matthew Thornton of New Hampshire, and Oliver Wolcott of Connecticut. Others were members of the Continental or United States Congresses.

Frank Chappell
AMA Science News Editor

Prepared by the American Medical Association.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

Found useful in the management of vertigo* associated with iseases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

Also available as Antivert (meclizine HCl) 12.5 mg. scored iblets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for ausea, vomiting and dizziness associated with motion sickness.

RIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



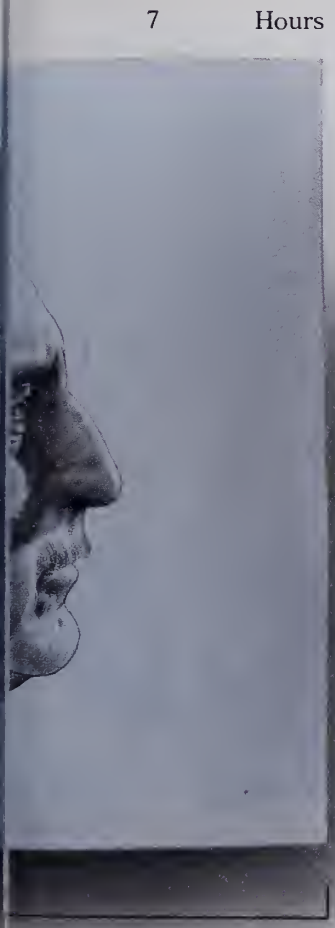
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories.[1-4]

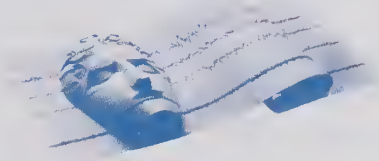
The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

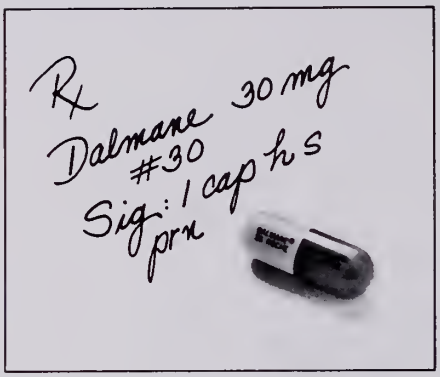
- □ induces sleep rapidly
- □ reduces nighttime awakenings
- □ lengthens total sleep time

ROCHE

Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) Ⓒ IV



Objectively proved in the sleep research laboratory, Dalmane

- □ induces sleep within 17 minutes, on average
- □ reduces nighttime awakenings
- □ provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum benefi effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971

2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medica Association, Houston, Apr 26-29, 1971

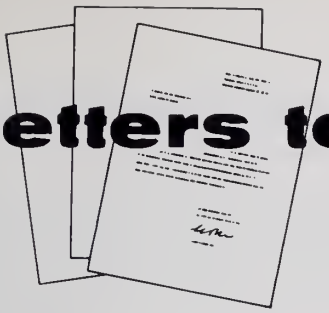
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



ROCHE

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Letters to the Editor

To the Editor: On reflecting the changes in medicine since I entered medical school in 1935, I was struck by the thought that although man hasn't changed in thousands of years, medicine has made countless tremendous technical advances in the short forty years since I first started my medical studies. These reflections prompted the following:

IN THE TEMPLES OF ASKLEPIOS

It is strange to behold
computers
in the temples of Asklepios.
There, with magic and mystery and science
the body and soul
were treated as one.
Now, this is gone.
The priest-physicians, depossessed by scientists,
wait in the wings
watching miraculous machines
cure the diseased and the deformed.
It is strange to behold
the whole man,
suffering from disease and strain,
torn apart.
The soul severed from the heart.
The spirit split from the brain.
But this I am told
the day will come
when the computer will feel
when the computer will know
of the anguish and woe
of the patient below
the towering machine.
But until then,
along with science,
I will practice my art
where the spirits dwell
trying to get the patient well.

With the hope that medical scientists will always remember their ancient roles as priest-physicians, I remain

Louis Alper, M.D.
Miami

To the Editor: We are in receipt of an inquiry on behalf of the Orange County Medical Society concerning the following question:

> "Is the medical doctor's wife legally liable for any of her husband's debts in the State of Florida?"

The essence of the question put another way asks, assuming a wife has what would be considered her separate property as opposed to properties owned jointly by the husband and wife, could such separate properties, real and personal, be subject to debts of her husband? It is my opinion that Florida Law and Appellate Court decisions interpreting this question answer the question affirmatively.

Prior to the 1968 revision of the Florida Constitution, a married woman's separate property, i.e., property she owned prior to marriage or afterward by gift, bequest, or purchase, could not be liable for debts of her husband without her consent given by some instrument in writing. The Florida Constitution adopted by the people of Florida 1968 provides in part in Article 10 §5:

> "There shall be no distinction between married women and married men in the holding, control disposition or encumbering of their property, both real and personal."

The people of our state in adopting the aforesaid constitutional provision in 1968, recognized that married women had assumed a position of independence in the marketplace, so the legal shackles which hindered the progress of married women in the business world should be removed. It would, therefore, seem inconsistent to say that the distinction between married women and men in encumbering their property is removed, and at the same time, hold that a married woman may be held liable for the payment of her husband's debt only if she executes an instrument in writing allowing such.

This inconsistency has been recognized by the Legislature of Florida and the courts of this state. In essence, the debts of a husband and wife are no longer in the eyes of law considered his or hers; but theirs.

John E. Thrasher
FMA Legal Counsel

Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

"Talk Back to Your Doctor"—How to Demand and Recognize High Quality Health Care by Arthur Levin, M.D., 245 Pages. Price $7.95, Doubleday & Company, Garden City, N.Y., 1975.

For me, this book was extremely difficult to review; in fact, it was hard to even read it, although my feelings may not apply to all of the profession who attempt it.

There are some valid criticisms of the medical profession and of the way medicine is practiced by some physicians, but the author appears to have taken all the bad examples and lumped them together with little or no mention of what is good in American medicine in areas away from the ivy towers. Initially, there is a note to the reader in which Dr. Levin anticipates the ire of the professional man who reads the book critically, but mentions that he welcomes this if it results in improved standards of health care.

The first chapter covers health care and statistics as he views them. This is followed by a chapter on selecting your doctor; thereafter, are chapters which cover the gamut of medical experiences that an individual may have during the course of his search for health, including diagnostic procedures, office and hospital care, diagnostic technology, use of drugs, "second opinions," hospital and posthospital care, surgeons and surgery, and finally, a chapter on the care (or lack of it) that women and children receive. The last chapter is devoted to the need for reform. There are many charts in the book, and quite a few "principles" which he discusses at some length. There is nothing in the book or on the wrapper to really indicate what Dr. Levin's clinical experience is, other than his references to hospital work, apparently while on the house staff. He is obviously biased in favor of HMOs, hospital outpatient clinics, increased cost of medical care (if all his recommendations are followed) and more paper work.

I believe I can best sum it up by saying that Dr. Levin believes that for the most part quality care in medicine is predominately obtained from young (under 35?), board certified specialists or subspecialists who practice in a group which is affiliated with a medical school associated teaching hospital, or who practice in a Neighborhood Health Center or an HMO.

If the book is to be recommended to the general public, it would sell best in very large cities where his requirements for "quality" medical care can possibly be found.

W. Dean Steward, M.D., F.A.C.P.
Marianna

Dr. Steward is an Internist, past president of the Florida Medical Association and the Florida Society of Internal Medicine. Previously in private practice, he is now County Health Officer, Jackson County.

Harper Dictionary of Contemporary Usage by William Morris and Mary Morris. 650 pages. Price $15.00. Harper & Row, New York, 1975.

Some books are a joy to have and use. For me, this one is a delight. It is the cooperative effort of a husband and wife team. William Morris is the Editor-in-Chief of The American Heritage Dictionary of the English Language. He and his wife, Mary, have also authored the multi-volume Dictionary of Word and Phrase Origins. In addition, they write a syndicated newspaper column.

Over several years they assembled a panel of consultants on usage which includes outstanding names such as Saul Bellow, Art Buchwald, John Ciardi, James B. Conant and Herman Wouk.

As an informative example, the use of the word **hopefully** is discussed. This has been widely misused in the sense of "we hope" or "it is hoped." The opinion of the majority of panelists was that they would reject the use of **hopefully,** in this sense, but would be somewhat more tolerant if it were used in informal speech.

The book was also helpful for me to explain to my office staff the difference between the verbs **affect** and **effect.** They explain it this way: **affect** means bringing about partial results and **effect** means to achieve complete results. "The cost of the farm program **affects** all our pocketbooks." "Arbitration was necessary to **effect** a settlement of the strike."

Where there is a difference of opinion regarding usage among the panelists, the authors include the specific comments of those panelists. This makes for interesting reading and, at least for me, makes language come alive.

The book is dedicated to the memory of two literary giants, W. H. Auden and H. L. Mencken. Auden felt that it was his duty, as a poet, to defend his language from corruption. The authors quote Mencken as saying "To the man with an ear for verbal delicacies—to the man who searches painfully for the perfect word and puts the way of saying a thing above the thing being said—there is in writing a constant joy of sudden discovery, of happy accident." This book may just increase that joy.

F.N.V.

But what is happiness except the
simple harmony between
a man and the life he leads?

—Albert Camus

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Physician's Handbook by Marcus A. Krupp, M.D.; Norman J. Sweet, M.D.; Ernest Jawetz, M.D.; Edward G. Biglieri, M.D. and Robert L. Roe, M.D. 18th Ed. 754 Pages. Price $8.00. Lange Medical Publications, Los Altos, Calif., 1976.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.-O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Diet Away Your Stress, Tension, & Anxiety by J. Daniel Palm, Ph.D. 227 Pages. Price $6.95. Garden City, New York, Doubleday & Company, 1976.

Emergency Management of the Critical Patient, Vol. 2, by J. Clifford Findeiss, M.D. 280 Pages. Price $17.95, Stratton Intercontinental Medical Book Corporation, New York, 1975.

Current Medical Diagnosis & Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1,062 Pages. Price $14.00. Lange Medical Publications, Los Altos, California, 1976.

Foreign Travel Immunization Guide by H. H. Neumann, M.D. 32 Pages. Price $2.50. To order: Send check to Box 611, New Haven, Connecticut 06503.

The Woman Alcoholic by Vera Lindbeck. 28 Pages. Price 35¢. New York, Public Affairs Pamphlets, 1975.

Focus on Care of the Elderly by Donald F. Phillips et al. 114 Pages. Price $4.75. Contemporary Publishing, Inc. Wakefield, Massachusetts, 1975.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus,** volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

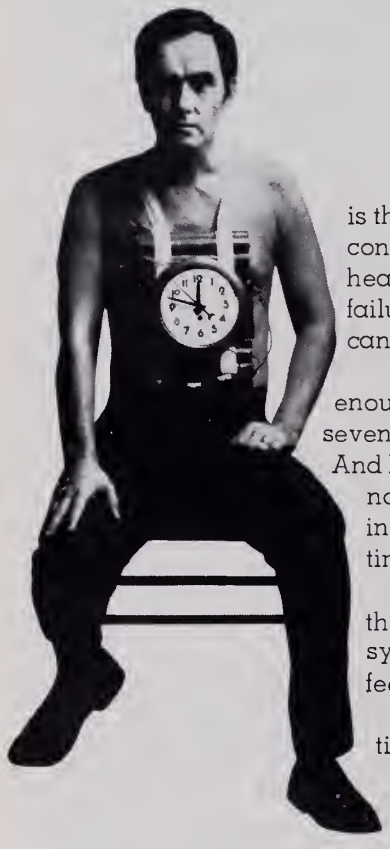
All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publications should be designated "For Publication."

ONE-SEVENTH OF YOUR EMPLOYEES MAY BE DYING. HELP SAVE THEIR LIVES.



High Blood Pressure is the country's leading contributor to stroke, heart disease and kidney failure. Any of which can kill.

And, frighteningly enough, one out of every seven of your workers has it. And half of them have no idea they're walking around with this time bomb inside them.

That's because there are usually no symptoms. The victim feels fine.

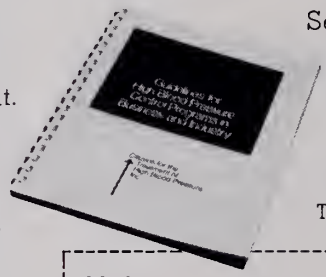
But all the while, the time bomb is ticking away.

Until, suddenly, it explodes.

But you can help. By giving your employees a chance to check their blood pressure. It takes only seconds to measure a person's blood pressure. And it's painless. Best of all, your own medical or nursing personnel can do the job, simply.

When a case of High Blood Pressure is detected, the employee is then referred to a doctor for treatment. And treatment is usually as simple as taking a pill every day.

To help you implement this life-saving program, we have a special kit, "Guidelines for High Blood Pressure Control Programs in Business and Industry." The kit includes complete instructions on screening, publicity, referral, follow-up, education. And more.



Send for your kit today. It may be the best thing you've ever done for your employees. And your company.

A Public Service of this Magazine & The Advertising Council

Mail to:

National High Blood Pressure Education Program
120/80, National Institutes of Health
Room 1012—Landow Bldg.
Bethesda, Md. 20014

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Title _____

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FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Warning
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Richard C. Dever, M.D., an FMA leader in Dade County for many years . . . has accepted the position of Vice President-Medical Director of Blue Shield of Florida in Jacksonville.

Dr. Dever, of Miami, is a former FMA Vice President and is currently a member of the Board of Governors and an Assistant Editor of **The Journal.**

A general surgeon in Miami for 18 years, Dr. Dever will move to Jacksonville, where his new appointment is effective April 1. He succeeds Thomas M. Irwin, M.D., who is retiring.

At Blue Shield, Dr. Dever's duties will include maintaining effective relationships and communications with medical organizations to promote acceptance and understanding of policies and procedures, especially in the area of claims payments.

Two Florida physicians . . . are among 24 psychiatrists selected nationally to make up the faculty for the Lederle Distinguished Lecturer Series in Psychiatry.

This educational service will offer to medical societies, medical schools and other professional audiences the opportunity to hear and meet with a noted authority in psychiatric medicine.

The Floridians, both on the faculty of the University of Miami Medical School, are: **Benjamin Brauzer, M.D.,** Associate Professor of Medicine, and **Burton J. Goldstein,** Professor of Psychiatry.

Any errors of omission or commission in this edition of The Journal should be directed to the Associate Editor (CMC), who was in charge of production for the week of March 15th while the Editor was in New Haven, Connecticut at Yale University giving the 18th Annual Grover F. Powers Memorial Lecture.

Edward G. Haskell Jr., M.D., who practiced in Tallahassee . . . before moving to South Carolina in 1974, has been appointed to a four-year term to the National Advisory Council on Health Professions by Dr. David Mathews, Secretary of the Department of Health, Education and Welfare.

Dr. Haskell also recently was appointed project director for the Area Health Education Center program, South Carolina's major effort to improve distribution of physicians and other resources.

Dr. Haskell is Associate Professor of Family Practice at the Medical University of South Carolina.



Dr. Lawson

Dr. Robert B. Lawson, Chief of Staff, Variety Children's Hospital in Miami, was honored by the Children's Memorial Hospital in Chicago by proclaiming October 1 Robert Lawson Day and by hanging the above commissioned portrait of Dr. Lawson (by Jill Cannady) in Children's Memorial Hospital in Chicago.

Dr. Lawson was Professor and Chairman of the Department of Pediatrics of the Northwestern University Medical School and Chief of Staff of The Children's Memorial Hospital, Chicago from 1962 to 1970.

In 1969, he was the first appointee to the Irene Heinz Given and John LaPort Given Chair of Pediatrics, and in 1970 to the newly-created post of Vice President for Health Sciences of Northwestern University.

In 1971, Dr. Lawson left Northwestern to assume his present position as Chief of Staff at the Variety Children's Hospital in Miami.

Woman's Auxiliary

TENTH ANNUAL BENEFIT ART SHOW

Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.).
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
4. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 21, 1976.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 4:00 p.m. Wednesday, May 5. Shipped entries will be refused.
8. All entries must remain on exhibition until 3:00 p.m., Saturday, May 8. They MUST be picked up between 3:00 and 4:00 p.m., Saturday.
9. We will not be responsible for entries not picked up by 4:00 p.m., Saturday, May 8.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to the St. Augustine Medical Museum.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $_____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

() A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.
Size: _____(H) X _____(W) To be hung on wall.

() B. Graphics. Include pen and ink, charcoal, photography, etc.
Size: _____(H) X _____(W)

() C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.
Size: _____(L) X _____(D) X _____(H)

() I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show."

An "Editor's Award," chosen by the Editor and his committee on Wednesday evening, May 5, will be used exclusively on the cover of a future issue of the Journal.

A registration fee of $10 will be charged for each entry. Make checks payable to:

WA-FMA ART SHOW
c/o Mrs. William F. Hogan
2861 N. E. 29th Street
Fort Lauderdale, Florida 33306

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 21, 1976

Judging will take place beginning at 10:00 a.m. on Thursday, May 6.

WOMAN'S AUXILIARY TO FMA

Golden Anniversary Meeting—May 5-9, 1976

DIPLOMAT HOTEL, Hollywood, Florida

Daily Schedule of Meetings and Activities

WEDNESDAY, MAY 5, 1976

10:00 a.m.-5:00 p.m.	Registration for all State Officers, Chairmen, and County Presidents—Mezzanine Lounge Pre-Registration for House of Delegates—Mezzanine Lounge.
11:00 a.m.-5:30 p.m.	Hospitality Room, Embassy Room, open
10:00 a.m.-5:00 p.m.	Tickets Available for Awards and FLAMPAC Luncheons—Registration Desk, Mezzanine Lounge
11:00 a.m.	Executive Committee Meeting — Suite of President, President-Elect
10:00 a.m.-2:30 p.m.	Deliver Art Show entries to booth in Exhibit Hall
1:00 p.m.	Pre-Convention Board of Directors Meeting, Mezzanine Theatre for ALL STATE OFFICERS, Chairman of Standing and Special Committees and County Presidents. ALL members are welcome as guests.

THURSDAY, MAY 6, 1976

8:00 a.m.-5:30 p.m.	VISIT HOSPITALITY ROOM, EMBASSY ROOM, "WOMEN IN ACTION" AND THE ART SHOW IN FMA EXHIBIT HALL ALL ENTRIES BY FLORIDA DOCTORS AND THEIR FAMILIES. HOSPITALITY ROOM WILL BE CLOSED DURING AWARDS LUNCHEON ON THURSDAY.
7:30 a.m.-8:45 a.m.	Complimentary Continental Breakfast for members of House of delegates—Mezzanine Lounge
8:00 a.m.-3:00 p.m.	Registration of all officers, Standing and Special Committee Chairmen, County Presidents, Delegates, Members and Guests, Mezzanine Lounge
9:00 a.m.-12:00 noon	First Session, House of Delegates—Mezzanine Theatre Delegates please wear identifying badges and be seated with your delegation by 9:00 a.m.
	Guest: Dr. Betty L. Siegel, Dean of Academic Affairs for Continuing Education, University of Florida
12:00 noon	Awards Luncheon, Cafe Cristal Room — Luncheon honoring Past Presidents and new County Auxiliary, Presentation of Art Show Awards, Editor's Award from the Journal of the Florida Medical Association, Peggy Wilcox Trophy and Membership and AMA-ERF.
2:00 p.m.	Second Session, House of Delegates, Mezzanine Theatre Delegates wearing badges should be seated with their delegation by 2:00 p.m. Memorial Service County Presidents' Reports Installation of 1976-1977 Officers

FRIDAY, MAY 7, 1976

7:30 a.m.-8:30 a.m.	Post Convention Auxiliary Board Meeting — Suite of President and President-Elect
8:30 a.m.-5:00 p.m.	Art Show—FMA Exhibit Hall
8:00 a.m.-12:00 noon	Hospitality Room, Embassy Room
& 2:00 p.m.-5:00 p.m.	Closed during FLAMPAC Luncheon
9:00 a.m.	Post Convention Board of Directors Meeting—Mezzanine Theatre. Orientation for all State Officers, Standing and Special Committee Chairmen, County Presidents, members and guests. Officers and Chairmen, please be ready to transfer files to new Board.
10:30 a.m.-12:00 noon	"Doctors Mistress" Mrs. Norman Evans Mr. Norman Evans, Offensive Tackle, Miami Dolphins
12:15 p.m.	Auxiliary-FLAMPAC Luncheon, Les Ambassadeurs Guest Speaker (to be announced)
6:30 p.m.-7:30 p.m.	FMA Cocktail Party — Poolside
7:30 p.m.	FMA Presidents' Dinner Dance Jerry Marshall Orchestra Miss Kelly Garrett

American Medical Association Education and Research Foundation

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

APRIL

Family Physicians Weekend, Apr. 2-4, Hilton Hotel, Gainesville. For information: Marshall D. Brainard, 4057 Carmichael Ave., Jacksonville 32207

"Highlights in Cancer—1976," Apr. 2, St. Vincent's Medical Center, Jacksonville. For information: Ashbel C. Williams, M.D., Cancer Education Dept., St. Vincent's Medical Center, Barrs & St. Johns Ave., Jacksonville 32204

Spring Symposium in Intensive Care, Apr. 2-5, Carillon Hotel, Hollywood, Florida*

Anesthesia for Cesarean Section, Apr. 4, University of Florida, Gainesville**

Current Research in Obstetrical Anesthesia, Apr. 6, University of Florida, Gainesville**

Current Practice on Cardiopulmonary Resuscitation of the Asphyxiated Newborn, Apr. 7, University of Florida, Gainesville**

Antimicrobial and Infectious Disease Symposium, Apr. 10, Orange Memorial Hospital, Red Auditorium, Orlando**

"Advances in Endocrinology," Apr. 8-9, Skycenter Inn, Jacksonville International Airport. For information: JHEP, 655 West 8th St., Jacksonville 32209

▸**Office Management of the Infertile Couple,** Apr. 9, Miami Beach. For information: Am. Fertility Soc., 1608 13th Ave. S., Birmingham, Al 35205

Fifth Annual Cardiovascular Consecutive Case Study Conference, Apr. 9-11, Sawgrass, Ponte Vedra (Jacksonville Beach). For information: Florida Heart Association, Box 10100, St. Petersburg 33733

Recent Developments in Gastrointestinal Surgery, Apr. 10-11, Pensacola Educational Program, Dept. of Surgery, 1200 W. Leonard St., Pensacola 32501

Ophthalmic Plastic & Corneal Surgery Symposium, Apr. 12-15, Doral Beach Hotel, Miami Beach*

Courses of Instruction in Coronary Care for the Practicing Physician, Apr. 19-24, Jackson Memorial Hospital, Miami*

Medical Symposium on Modern Management and Chemotherapy of Tuberculosis, Apr. 22, Hilton Inn West, Orlando. For information: Marianne B. McEuen, M.D., P.O. Box 210, Jacksonville 32201

Asymptomatic Coronary Artery Disease: Early Detection and Management, Apr. 22-23, Sheraton Towers, Orlando**

Cancer Conference: Cancer Detection in the Physician's Office, Apr. 23, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

▸**American Laryngological Association, Inc.,** Apr. 24-25, The Breakers, Palm Beach. For information: John F. Daly, M.D. 566 First Avenue, Suite 3F, New York 10016.

▸**Symposium in Cardiovascular Nursing,** Apr. 24-27, Sheraton Sand Key Hotel, Clearwater. For information: Am. Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014

▸**American Otological Society, Inc.,** Apr. 25-26, The Breakers, Palm Beach. For information: G. Dekle Taylor, M.D., 221 Marshall Taylor Doctors Bldg., Jacksonville 32207.

▸**American Neurotology Society,** Apr. 26, The Breakers, Palm Beach. For information: Jack L. Pulec, M.D., 2122 West 3rd St., Los Angeles, Ca. 90057.

▸**American Laryngological, Rhinological and Otological Society, Inc.** (The Triological Society), Apr. 27-29, The Breakers, Palm Beach. For information: Richard L. Ruggles, M.D., 11201 Shaker Blvd., Cleveland, Ohio 44104.

▸**American Broncho-Esophagological Association,** Apr. 27-28, The Breakers, Palm Beach. For information: Loring W. Pratt, M.D., 325 Kennedy Memorial Drive, Waterville, Maine 04901.

Biomedical Role of Trace Elements in Aging, Apr. 28-30, Ecker College, St. Petersburg. For information: Alfred H. Lawton, M.D., V. A. Center, Bay Pines 33504.

▸**American Academy of Facial Plastic and Reconstructive Surgery, Inc.,** Apr. 29-May 1, The Breakers, Palm Beach. For information: M. Eugene Tardy Jr., M.D., 2800 Lake Shore Drive, Suite 4008, Chicago, Il. 60657.

MAY

Circuit Courses in Continuing Medical Education, May 1, Holiday Inn-Oceanside, Fort Pierce.*

Renal Disease, May 1-2, Holiday Inn, Ft. Pierce*

Neurological Disorders, May 1-2, Holiday Inn, Ft. Pierce*

One Hundred Second Florida Medical Association Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

▸ National meetings being held in Florida.

Sexual Dysfunction and Alternate Life Styles, May 7, Aboard the SS Monarch*

Dental Analgesia and Anesthesia Seminar, May 7-9, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., Mount Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140.

Neurology for Non-Neurologists III, May 13, University of South Florida, Tampa+

The 26th Annual Postgraduate Seminar: Medical-Surgical Dilemmas, May 13-15, Mount Sinai Medical Center, Miami Beach. For information: Miniver S. Reed, CME Coordinator, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140

Cerebral Circulation and Metabolism, Intracranial Pressure and Anesthesia, May 17, University of Florida, Gainesville**

Anesthesia in the Patient on Chronic Drug Therapy, May 18, University of Florida, Gainesville**

Current Status of Halogenated Anesthetic Drugs, May 20, University of Florida, Gainesville**

Gastrointestinal Endoscopy, May 20-21, Americana Hotel, Miami Beach. For information: Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202

Scientific Bases of Clinical Practice, May 20-23, Innisbrook Resort & Golf Club, Tarpon Springs**

Cancer Conference: Serum Enzymes in Diagnosis of Malignancy, May 28, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

1976 Physicians' Seminar on Respiratory Disease, May 28-30, Turtle Inn, Atlantic Beach. For information: A. J. Azcuy, M.D., Box 8127, Jacksonville 32211

Colon Cancer and Lymphadenopathy, May 29, Flagler Hospital, St. Augustine. For information: S.A. Gunn, M.D., 159 Marine St., St. Augustine 32084

Master Approach to Acute Cardiac Care, May 29-31, Contemporary Hotel, Walt Disney World*

Third Annual Family Practice Review, May 31-June 4, Hilton Inn, Gainesville**

Spring Symposia & Cruise in Obstetrics & Gynecology, May 31-June 6*

JUNE

Bascom Palmer Eye Institute Annual Residents Day, June 1976, Key Biscayne Hotel, Key Biscayne*

1976 Clinical Conference on Pre-Hospital Emergency Care, June 12-14, Orlando Hyatt House, Kissimmee. For information: ACEP, 1919 Beachway, Suite 5-C, Jacksonville 32207

Florida Suncoast Pediatric Conference, June 14-16, Sheraton Sand-Key, Clearwater*

10th Annual Workshop in Electrocardiography, June 21-26, Sheraton Sand-Key Hotel, Clearwater Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

Florida Academy of Family Physicians Assembly, June 23-27, Marco Island. For information: Marshall D. Brainard, 4057 Carmichael Ave., Jacksonville 32207

Cancer Conference: Annual **Report—Cancer Therapy End Results** at St. Joseph's Hospital, Auditorium, June 25. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

SEPTEMBER

Clinical Electrophysiology, Sept. 15-17, Wolfson Auditorium, Mount Sinai Hospital, Miami Beach. For information: CME Coordinator, Mount Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

Twenty Fourth Annual Diabetes Seminar, Sept. 17-19, Jacksonville. For information: Robert Miller, M.D., 1545 San Marco Blvd., Jacksonville 32207.

OCTOBER

Topics in Family Medicine 1976, Oct. 6-10, University of Miami School of Medicine, Department of Family Medicine*

17th Workshop in Electrocardiography for Cardiac Nurses & Interested Physicians, Oct. 14-18, Tides Hotel, Redington Beach, St. Petersburg. For Information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel, Key Biscayne.*

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SEE INSTRUCTIONS ON PAGE 2 (REVERSE)

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Edward O. Hagan

Executive Editor

Classified Ads

physicians wanted

FAMILY PRACTITIONERS

MIAMI, FLORIDA: G.P. — Seven man multi-specialty, fee-for-service group is seeking a G.P. to join the group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

GENERAL PHYSICIAN—Florida State University Health Center, a primary care facility. Very attractive North Florida location, salary negotiable, fringe benefits, liability insurance provided, no Florida license required. An equal opportunity employer—applications from women and minorities welcomed. Submit curriculum vitae with inquiry to Dr. Philip C. Rond, Director, Florida State University Health Service, Tallahassee, Florida 32306.

WANTED: FAMILY PRACTITIONER to locate in North Florida town near Jacksonville. New office, financing available to set up practice. Write C-722, P.O. Box 2411, Jacksonville, Florida 32203.

CENTRAL FLORIDA MULTISPECIALTY CLINIC has opening for third general practitioner. Congenial group; good financial opportunity; new well equipped office near hospitals. Write C-723, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST—FAMILY PRACTICE: Central Pasco immediate area 15,000. Drawing area without internist additional 30,000. Medical Center opens August 1, 1976. Share facilities, other specialties have leased. Administrative secretarial services provided. Turn Key. Participation available. 20 miles north of Tampa. Write: Central Pasco Medical Center, P.O. Box 206, Land O'Lakes, Florida 33539.

GENERAL PRACTICE—INTERNIST: Exciting opportunity to work with rapidly growing HMO in Miami area. Full benefits package including pension plan, Malpractice coverage, family health, paid vacation. Send CV to Daniel E. Tillotson, V.P., American Health Plan, Inc., 1701 N.E. 164 St., N. Miami Beach, Florida 33162. Phone (305) 944-2921.

SPECIALISTS

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

MIAMI, FLORIDA AREA: Multispecialty group fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

ORTHOPAEDIC SURGEON — FLORIDA PRACTICE. Board qualified or certified to join 2-man highly reputable orthopaedic practice in beautiful community. Send professional and personal critique to L. Cerino, M.D., 1800 North Federal Highway, Pompano Beach, Florida 33062. Phone: (305) 943-1922.

OUR PRESENT DEPARTMENT OF PSYCHIATRY is a three man department. We wish to double the size of this over the next three to four years. All candidates must be Board eligible. General psychiatrists or someone with subspecialty interests would be acceptable. Our department is a member of a multi-specialty group located in Pensacola, Florida. Inquiries should be sent to W. M. C. Wilhoit, M.D., Chairman, Department of Psychiatry, The Medical Center Clinic, 1750 N. Palafax St., Pensacola, Florida 32501.

INTERNIST NEEDED: Board certified or board eligible with special interest in cardiology. New 180-bed rural community hospital in central Florida with 10-bed coronary care unit and no Internist. Will build, equip and lease new office OR salary and fringe benefits available as employee of existing PA composed of four family physicians practicing quality medicine. Starting salary range $50,000-$60,000. Write C-707, P.O. Box 2411, Jacksonville, Florida 32203.

TWO ANESTHESIOLOGISTS NEEDED: Growing multispecialty group seeks affiliation with board certified or eligible anesthesiologists. Excellent opportunity to either join group or provide service to its staff and other physicians in the community. Beautiful northeast Florida coastal city with excellent hospitals and good school system. Write C-698, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN WANTED IMMEDIATELY: Gynecologist, board certified/eligible to be salaried Medical Director of innovative, ambulatory Women's Clinic in University town (medical school and teaching hospital). All Gyn. services, pregnancy terminations, laparoscopy, colposcopy, tubals, etc. Minimum first year $40,000; paid malpractice insurance; 35-40 hour week. Write C-724, P.O. Box 2411, Jacksonville, Florida 32203.

MISCELLANEOUS

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PSYCHIATRIST/G. P. PHYSICIAN — Openings are anticipated from time to time in well established Community Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse, Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume', should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

POEMS WANTED: The Florida Society of Poets is compiling a book of poems. If you have written a poem and would like our selection committee to consider it for publication, send your poem and a self-addressed stamped envelope to: The Florida Society of Poets, P.O. Box 1976, Riverview, Florida 33569.

FLORIDA COUNTY HEALTH DIRECTOR VACANCIES in Pasco, Alachua, Clay and Hernando Counties; must be eligible or have Florida license. Salary range $32,000-$34,000. Apply to Dr. John F. McGarry, Chief, Bureau of Local Health Services, Department of Health and Rehabilitative Services, P. O. Box 210, Jacksonville, Florida 32201.

WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital 150 beds. Forty hour week. Benefits include four weeks vacation and one week for medical meetings. Starting salary $40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: Jack Geeslin, M.D., Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-3128.

FULL-TIME ER PHYSICIAN—For modern, expanding, fully-accredited 467-bed regional medical center with low malpractice insurance rates, salary and fringes negotiable, progressive staff with specialty back up. Excellent schools, college facilities, cultural activities, recreational activities. Contact Dan S. Wilford, Administrator, North Mississippi Medical Center, 830 South Gloster Street, Tupelo, Mississippi 38801. Phone: (601) 842-3632.

SEEKING PHYSICIANS to relocate Marianna, Florida, trade area of 40,000 people. Recent professionals study indicated the immediate need for 7 physicians to supplement the 6 already here. Financial and business assistance available to qualified physicians. Contact Elwin O'Steen. Phone: (904) 482-4011.

FLORIDA MULTISPECIALTY CLINIC NEEDS PHYSICIANS. 90 minutes from two major university medical centers. New 220-bed hospital with second new hospital under construction. Group practice, fee for service or guaranteed salary. New clinic with x-ray and lab. The Chessick Clinic, 101 Seminole Avenue, Inverness, Florida 32650. Phone: (904) 726-9180.

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Situations Wanted

PHYSICIAN'S ASSISTANT FROM INDIANA UNIVERSITY seeking employment in Florida, preferably Orlando area. Ex-naval corpsman, surgical technician, emergency room, and family practice experience. Available for a three-four month preceptorship on May 1 or June 1, 1976. Graduates August 1976. Reply to Richard L. Woodard, 6008 Moeller Road, Lot #50, Fort Wayne, Indiana 46806.

PATHOLOGIST, 39, married, board certified in anatomic and clinical pathology, 6 years experience in large community hospital, seeks position of associate or director available July, 1975, national boards, Florida licensed. Write C-716, P.O. Box 2411, Jacksonville, Florida 32203.

HOSAIN DAEE, M.D., board eligible OB/GYN with Florida license seeking group practice. Available July 1, 1976. Call: (518) 445-5013 or Dept. OB/GYN, Albany Medical Center Hospital, Albany, New York 12208.

NEONATOLOGIST, Florida licensed, interested in level 2 perinatal center or hospital-based position with strong emphasis on the neonatal unit. Experienced in clinical care and teaching. Available July 1976. Write C-720, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED: INSTITUTIONAL OR ADMINISTRATIVE POSITION, clinical or nonclinical, large mental hospital, etc., (except Veteran's Administration): by 51 year old WASP board-certified internist. American native, American trained. Florida license plus 6 others and National Boards. Any position, anywhere considered. Available now. Write C-726, P.O. Box 2411, Jacksonville, Florida 32203.

GASTROENTEROLOGIST, age 33, certified in IM and GE. Experienced in ERCP, polypectomy and laparoscopy. Available summer 1976. Seeks group in Florida. J. Wilcoxen, M.D., 13000 N. 30th St., Tampa, Florida 33612.

BOARD CERTIFIED CARDIOLOGIST, trained in all aspects of diagnostic cardiology. Seeking to relocate in Florida. CV upon request. Write C-727, P.O. Box 2411, Jacksonville, Florida 32203.

FULL TIME ADMINISTRATIVE POSITION desired by MD with government, drug, insurance, or related organization. Write C-728, P.O. Box 2411, Jacksonville, Florida 32203.

Practice Available

LARGE INTERNAL MEDICAL PRACTICE FOR SALE with office for rent and equipment for sale or lease and completely staffed. Write C-725, P.O. Box 2411, Jacksonville, Florida 32203.

Equipment for Sale

FOR SALE: (1) Pelton Steam autoclave. (2) Burdick Microwave diathermy unit. (3) Burdick Muscle stimulator. (4) One articulated skeleton. (5) Picker x-ray unit, 300 ma, 125 pkv. 90/15 tilt table, fluoroscope, spot film device, floor to ceiling tube stand with electromagnetic locks, videx collimator, electronic bucky, 12/1 grid. Contact Alex Trombly, (813) 253-0481, 8:00 - 5:00.

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ST. PETERSBURG: Pasadena Medical-Dental Building, 419 Pasadena Avenue South. New deluxe office building. Just minutes from Palms of Pasadena and St. Petersburg General Hospitals. Custom designed for your needs. For complete information call Gerald F. Dalrymple (813) 866-2474.

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FOR RENT, WEST PALM BEACH: Unusually good central location on South Flagler Drive. New, one story building. Parking. Call (305) 655-8620.

FORT MYERS, FLORIDA, distinctive air-conditioned suite, new medical center, including x-ray lab. Nine doctors tenants, only $4 square foot. Financial assistance if required. Phone collect evenings (813) 542-0501.

FOR LEASE: Medical Arts Building, Florida. Gulf Coast, Clearwater, St. Petersburg area. Super location across street from 300-bed general hospital. For information write Medical Arts Building, P.O. Box 999, Dunedin, Florida 33528.

SANIBEL ISLAND FLORIDA: New medical building, excellent location, 1,100 sq. ft., air conditioned, panelled, soundproofed, carpeting, draperies, two treatment rooms, private office, two rest rooms, large waiting room. Will divide into two 550 sq. ft. units. Other tenants—dentists and optometrist. Call or write Bette O. Parke, Baywind Plaza, 2402 Palm Ridge Road, Sanibel, Florida 33957. Phone: (813) 472-2946.

WINTER HAVEN: Share new 3,000 sq. ft. office in medical complex. Large reception and business areas, 4 examining rooms, built-ins, carpeting, etc. Phone office manager, M. E. Pent (813) 293-2147 for information.

NEW HOLLYWOOD MEDICAL CENTER PROFESSIONAL BUILDING, part of Hollywood Medical Center, a 334-bed general hospital. Office custom built for your needs. Contact: Gladys Ross, 3700 Washington Street, Hollywood, Florida 33021. Phone: (305) 966-4500 Ext. 108.

PROFESSIONAL OFFICE FOR RENT, 2250 South Dixie Highway. 4,000 square feet. 1 story brick. Off street parking area. 2,200 square feet exquisite 2 doctors' completely equipped suite, also 1,800 square feet remodeled to suit. Call (305) 856-5170, Miami, Florida.

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The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville, Florida 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

DOCTOR.....

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102nd ANNUAL MEETING
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DIPLOMAT HOTEL, HOLLYWOOD

Advertisers

Auto Leasing
Service 292

Burroughs Wellcome Co.
Neosporin 263

Convention Press 266, 295

Dow Pharmaceuticals
Novafed A Capsules 286a

Geriatric Pharmaceutical Corp.
Menic 296

Hill Crest Hospital
Service 290

Lederle Laboratories
Incremin 285

Eli Lilly & Co.
Kefzol 270

Loma Linda Foods
I-Soyalac 306a

Mead Johnson
Vasodilan 286

Ortho Pharmaceuticals
Vermox 268, 269

Pharmaceutical Manufacturers Assn.
Institutional 258, 259

Psychiatric Institute of Mexico City
Institutional 296

Roche Laboratories
Bactrim Third and Back Covers
Valium 254, 255
Dalmane 302a

Roerig, A Division of Pfizer Pharmaceuticals
Antiminth 266, 267
Antivert 302a

Sapphire Valley
Mountain Resort 313

Smith, Kline & French
Dyazide 306a

TELL-A-PHONE of Florida
Service 262

Westwood Pharmaceuticals, Inc.
PreSUN 311

Willingway Hospital
Service 292

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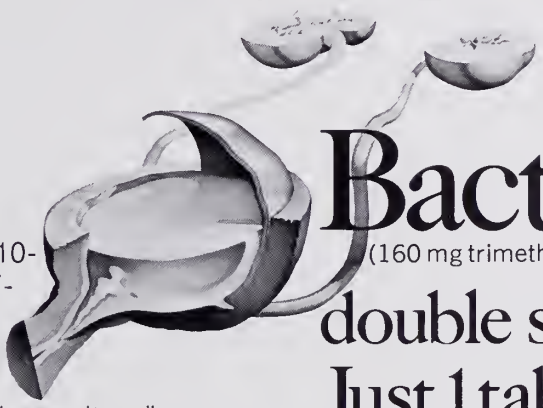
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1976 FMA Annual Meeting, May 5-9, Diplomat Hotel, Hollywood

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions were mild (*e.g.*, nausea, rash), more serious reactions can occur with these drugs. See manufacturers' product information for complete listing.

Note: Bactrim single strength tablets were used in these clinical trials. However, studies have established the bioequivalency of Bactrim DS with the single strength tablets.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

double strength tablets Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

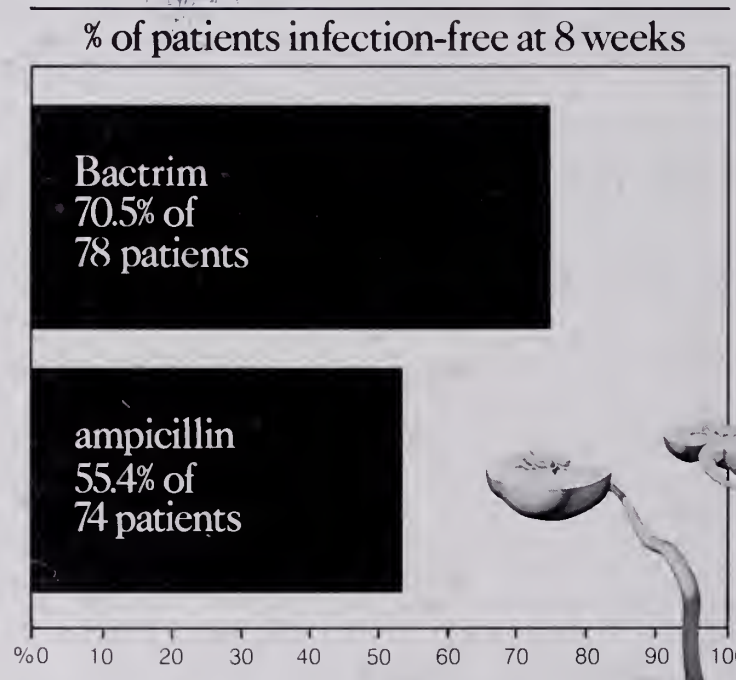
Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

ROCHE

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Nutley, New Jersey 07110

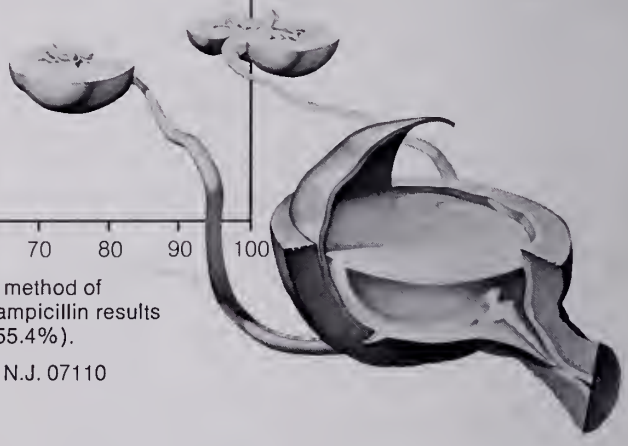
In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim™ was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110



Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
double strength tablets
Just 1 tabl[illegible]D.

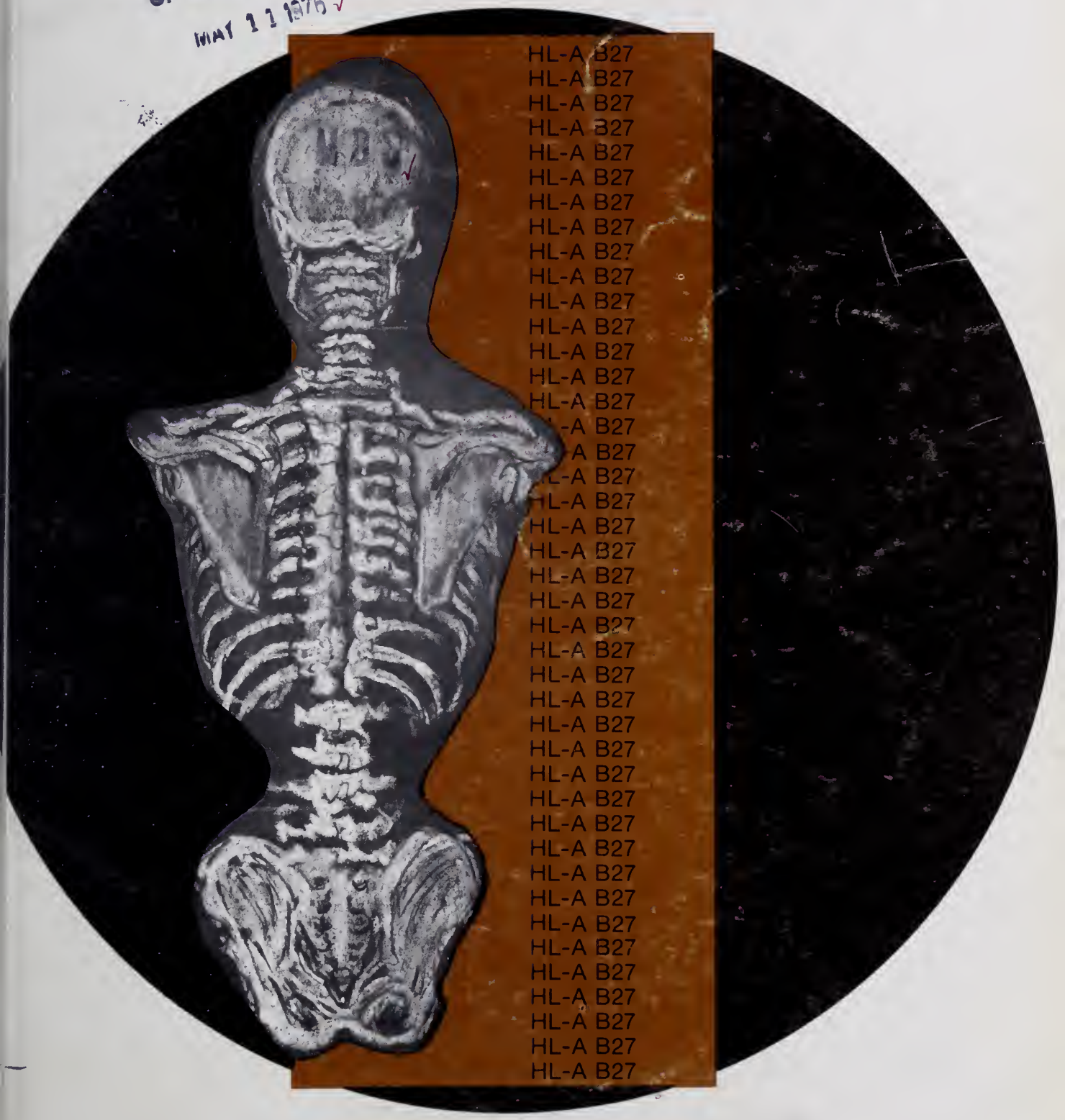
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2 tablets B.I.D.

Please see summ[illegible]t infor on preceding page

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MAY 11 1976



The HL-A B27 Histocompatibility Antigen in Rheumatoid Arthritis Variants — Page 339

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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Scientific Articles

The HL-A B27 Histocompatibility Antigen in Rheumatoid Arthritis Variants
Robert G. Gray, M.D. and Norman L. Gottlieb, M.D. **339**

Cranio-Orbital Correction of Severe Facial Deformity—A New Horizon in Corrective Surgery
Mutaz B. Habal, M.D. and Jack E. Maniscalco, M.D. **345**

Treatment of Infected Cardiac Pacemaker Site With Closed Irrigation—Report of Case and Subject Review
Osvaldo Contarini, M.D. and R. Daley Goff Jr., M.D. **349**

Special Articles

Community Mental Health Centers or Is There A Better Way?
Philip B. Phillips, M.D. and Roswitha B. Fischer, M.A. **353**

Epidemic Transient Situational Disturbance in an Elementary School
Joel L. Nitzkin, M.D., M.P.H. **357**

Sections

President's Page
My Thanks to All
VERNON B. ASTLER, M.D. 325
Books Received 377
Book Reviews 376
Commentary
Large Scale Flu Vaccine Program Planned
E. CHARLTON PRATHER, M.D., KENNETH A. HORN, M.D. and LARRY A. DODD 372
Dean's Page
Growth of a Statewide On-Site Education Program (Cancer)
E. M. PAPPER, M.D. 336
Editorial
Reflections 361
Legislative News
Pot Pourri
JOHN C. KRUSE, M.D. 332
Letters to the Editor 379
Medical News Around the State 375
Organization
Dr. Astler's Year as Our President
D. L. VAN ELDIK, M.D. 367
AMA President Delivers First Jere Annis Lecture ... 369
Dr. Burns A. Dobbins Honored by Broward Colleagues 370
Others Are Saying
A Visit to the Doctor or What's it Like to be a Patient?
DANIEL B. NUNN, M.D. 381
Politics is Making Bad Medicine
EDWARD W. ST. MARY, M.D. 382
The Physician and His Manners
JAMES J. CRUMBLEY JR., M.D. 383

Information

Classified Advertising 387
FMA Officers and Council Chairmen 390
Information for Authors 377
Index to Advertisers 390
Meetings 384

MAY COVER — The artistic talent and creativity within Florida's physician families continues to add much to the flavor of the Journal. This cover for the May issue was designed by Mary Alice Doff (Mrs. Simon D. Doff)—a Jacksonville artist of note. It highlights the feature article entitled "The HL-A B27 Histocompatibility Antigen in Rheumatoid Arthritis Variants."



President's Page

My Thanks to All

Since this represents my final President's Page, I felt a brief review of some of the past 12 months' happenings might be of interest.

As the year began in May of 1975, FMA members were under threat from Argonaut Insurance Company of imminent withdrawal and abrogation of its responsibilities under the terms of our Professional Liability Insurance contract. Your FMA Board of Governors had wisely countered early legal opinion to comply with Argonaut's demands by enjoining the company in a law suit at a total cost approaching $100,000. We prevailed in this suit with an immediate savings to FMA insured members of almost $14 million in illegal premiums that had to be returned. This victory also allowed time for the formation of our own PLI Trust. The finest available national experts in the field of insurance, underwriting, actuarial data, insurance law, etc. were retained and we formed our self insurance trust on a hurried time schedule necessitated by a judicially imposed deadline of January 1, 1976.

We were able to hold the January 1, 1975 rate schedule which proved to be 2½ to 3 times less than the comparable rates offered by the Joint Underwriting Association (JUA). The selection and/or rejection of applying members by the Trust was carried out in a business-like manner based upon guidelines and advice rendered by legal counsel, actuaries, insurance professionals, and with serious consideration given to county medical societies' recommendations. While the decision to reject a very small percentage of members was admittedly unpleasant, the alternative choice of indiscriminate or blanket acceptance of all applicants seemed much less advisable. The latter course would likely result in unfavorable claims experience and ultimate failure of our program to the serious detriment of the overwhelming majority of FMA participants.

We later accumulated essential data and retained expert counsel to appear at hearings relating to Workmen's Compensation fee schedules at a cost approaching $20,000. We were ultimately able to achieve an approximate 32% across the board increase in physician's fees after a period of several years without any increase in physician benefits. This belated adjustment of fees should result in between $17 and $19 million annual increase in physician's fees in Florida.

A decision was accomplished to rescind HEW guidelines regarding reimbursement for laboratory procedures and will serve to protect small laboratories performing noncomputerized services allowing them similar fees to those done under computerized services.

We reorganized and strengthened our legislative staff and program and through the liquidation of another asset were able to purchase and renovate a new Capital Office Building in Tallahassee without utilizing any membership dues.

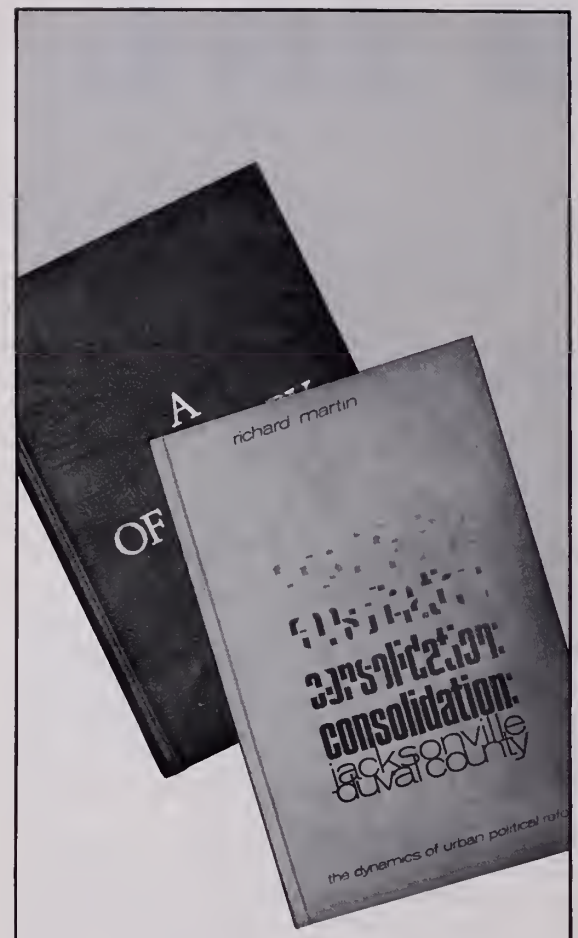
Our public relations program was totally revitalized and proper professional personnel retained to carry out the program. The ultimate wisdom of the House of Delegates in approving a $100 assessment for legislative and public relations purposes in January will not be fully realized for some time. Our staff has already acquired a fully optimistic outlook and is approaching the job at hand with new vigor.

Our Continuing Medical Education program has been revised and clarified this year.

In Florida, Emergency Medical Services have received national attention and significant headway has been accomplished in this all-important area.

All this could not have been accomplished without a strong Board of Governors plus a truly superior staff. But most important was an excellent, well informed, and sympathetic membership of which I am proud and to whom I am thankful.

Vernon B. Astler



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Vermox chewable tablets
(mebendazole)

DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival.
An insignificant amount of mebendazole is absorbed from the gastrointestinal tract. Most of this is excreted in the urine within three days either as metabolites or unchanged drug.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.
Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99 7%	99 9%	—
(range)	(70-99%)	(99 5-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.
PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults.
For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.
For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.
If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

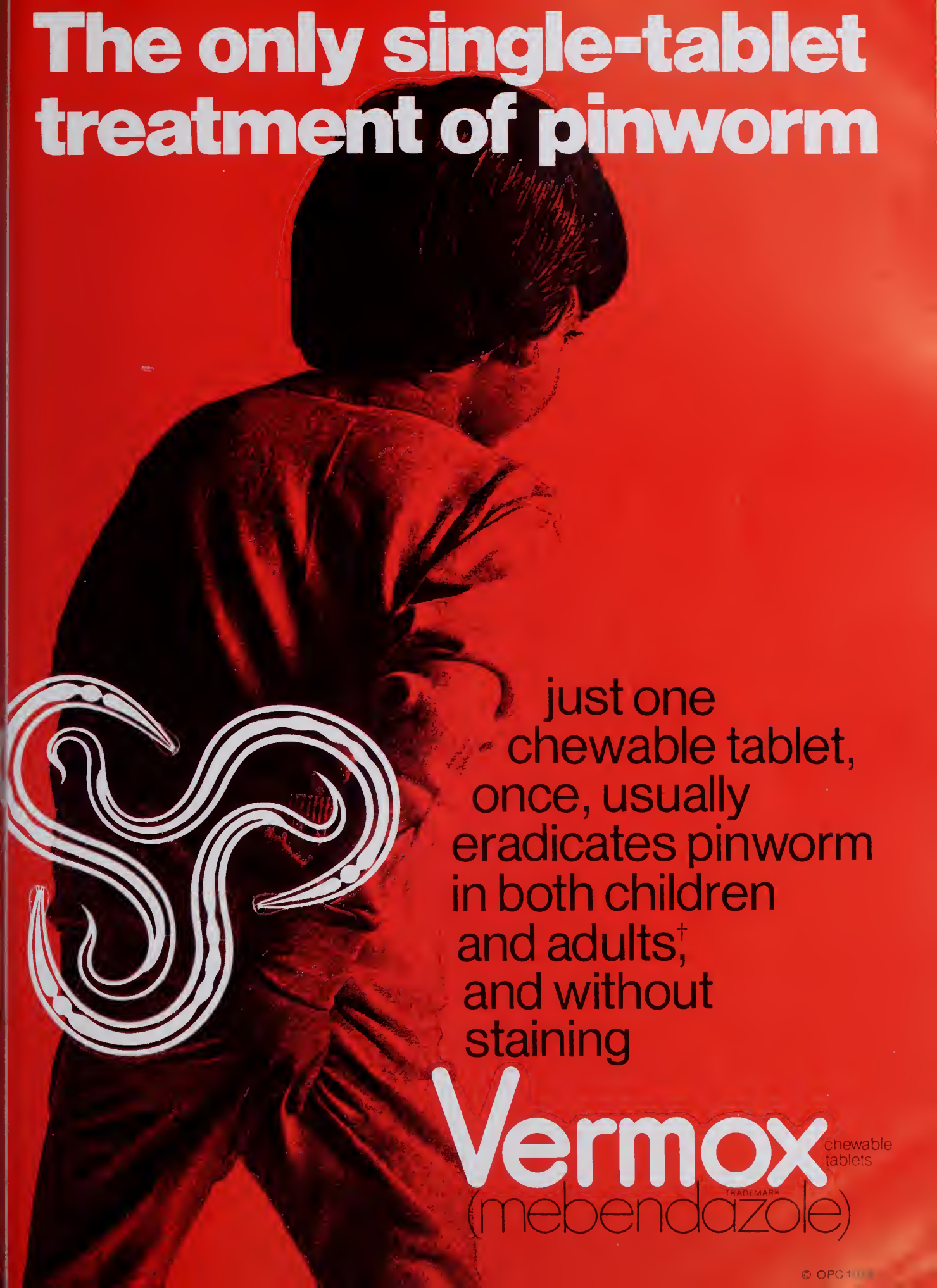
HOW SUPPLIED VERMOX is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium, and co-developed by Ortho Pharmaceutical Corporation.

† Because Vermox has not been extensively studied in children under 2 years of age, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

OJ 288-5R

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The only single-tablet treatment of pinworm



just one chewable tablet, once, usually eradicates pinworm in both children and adults†, and without staining

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(mebendazole)

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Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital (warning: may be habit forming)	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

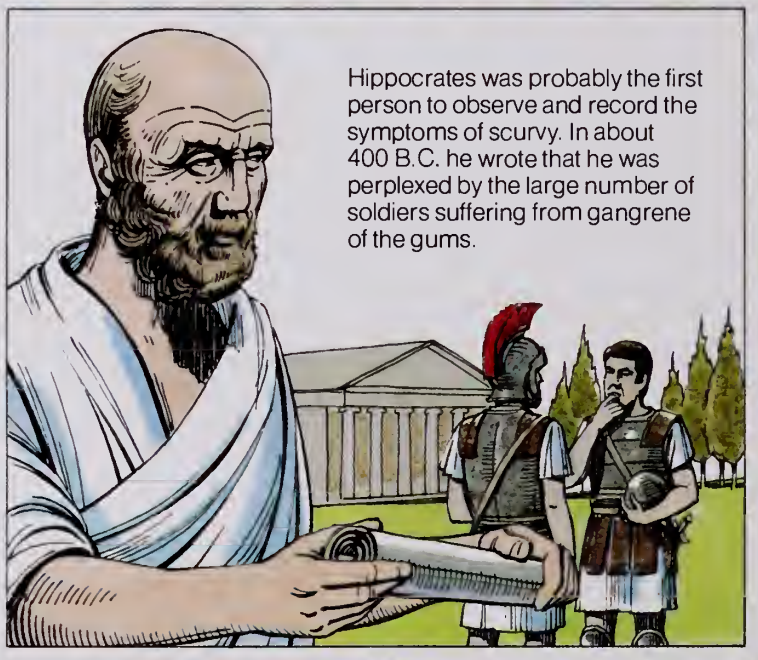
Brief summary. Adverse Reactions: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Contraindications: Glaucoma; renal or hepatic disease; obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); or hypersensitivity to any of the ingredients.

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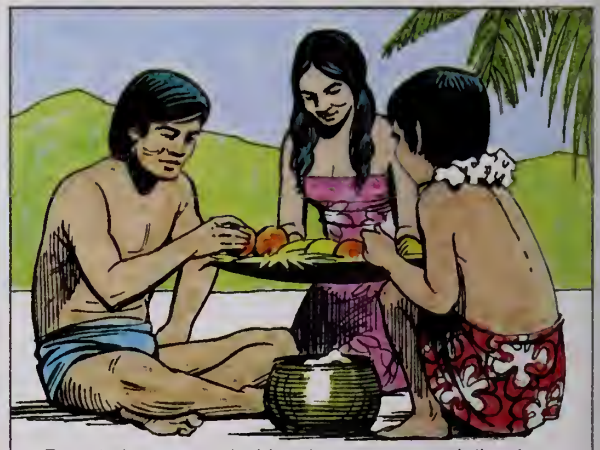
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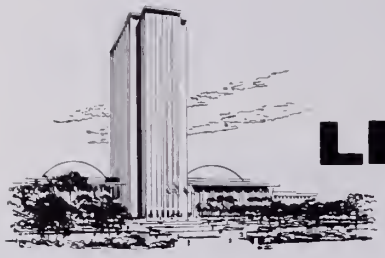


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LEGISLATIVE NEWS

Pot Pourri

By the time this issue of JFMA reaches you, many events will have transpired in Tallahassee and some of the information in this month's column will be out of date, as it is being written on March 31, 1976; however, the information on most of the bills will be current.

Last month's column related that Rep. Steinberg of Miami Beach had introduced HB 2528 which would have mandated a 14-day delay in insurance payments while the patient examined his bill to be sure he actually received the enumerated services. This bill was defeated on March 30 in the House Subcommittee on Insurance. The FMA was very much a part of the action that brought about the defeat of this bad bill.

Other bills of interest to FMA members at this time include SB 491 (Poston) and its House companion, HB 2546 (Becker) which mandate that all state medical schools admit for one year of clinical training so-called "Fifth Pathway" graduates of foreign medical schools. It would be required that "the current yearly enrollment of (such) medical students . . . shall not be less than 10% of the total number of medical doctor degrees granted . . . in the previous year." This would create an enormous burden on our medical schools, dilute the quality of clinical training received by the regularly enrolled students at the schools, and would not assure a top quality practitioner emerging at the end of such year of training. The FMA's position is that the law passed last year is sufficient to assure good quality Fifth Pathway students and that no further legislative intervention is necessary.

Two bills relating to the regulation of abortion have been introduced. HB 1160 (Singleton & others) would prohibit experimentation on a live fetus and require that when there is any chance of fetal survival, the procedure used to terminate the pregnancy affords the fetus the best chance of survival. Violation would be a first degree misdemeanor. SB 60 (McClain) requires that two physcians certify that an abortion after the 24th week of gestation is necessary to save the life of the pregnant woman. Violation would be a third degree felony.

In addition to HB 2740 (Coolman) which permits unlimited drug substitution, HB 2950 (Considine), which also permits drug substitution, has been introduced. This bill spells out that the pharmacist would incur responsibility for his substitution, but does not require prior approval by the physician. The physician would have to write "dispense as written" in his own handwriting on the prescription. It would also require the Board of Pharmacy and the State Board of Medical Examiners to establish a formulary listing those drugs for which substitution is prohibited. Such a list would be distributed to all pharmacists and physicians in Florida.

Discussions have been held between the FMA and the Pharmacists Association concerning these bills. The pharmacists are under the burden of the April 26, 1976 deadline set by the U.S. Department of HEW. On that date, drugs paid for by federal programs will be paid for only up to a maximum allowable cost (MAC). The federal regulations also require that any excess cost come out of the pharmacist's pocket if he is unable to substitute a cheaper drug. The committee and the FMA staff are working with the pharmacists to try to arrive at common ground in this issue made more difficult by further federal intervention in the private sector.

One of the profound changes in the health care scene in Florida was the passage of the Department of HRS reorganization bill by last year's legislature. The FMA's position was that this would create a bureaucratic nightmare. We vigorously opposed this bill but we did not prevail. Our warnings are now starting to come true and HB 2849 (Dixon) would again establish an independent Department of Health and an independent Department of Social and Rehabilitative Services. The Secretary of Department of Health would be by statute an M.D. or D.O. The organization follows closely the Division of Health that served the people of Florida so well in

the past. Whether this bill can be passed so soon after the reorganization of HRS remains to be seen, but the committee and the FMA staff will be following HB 2849 very closely.

Finally, the progress to date on our Professional Liability Insurance package has been gratifying. A two week "blitz" involving all the FMA's staff in Jacksonville and Tallahassee resulted in contact with virtually all members of the legislature. In addition, the key contact physicians were given the package to present to their legislators. The results showed widespread support and sympathy for our position and good, positive response towards our package. The committee and staff are working closely with the key House and Senate Committee staffs and we have had our package introduced **in toto** on both sides of the Capitol. Our opposition, the Trial Bar, is of course yet to be heard from and the legislative process has not yet begun to work in earnest. My personal feelings at this point are one of guarded optimism. We will be getting some kind of legislation in this area, but the flavor of the "sausage" is as yet unpredictable!

John C. Kruse, M.D., Chairman
FMA Committee on State Legislation
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Dean's Page

Growth of a Statewide On-Site Education Program (Cancer)

E. M. Papper, M.D.

In the February issue of this journal (Dean's Page) we stressed the participation of the University in continuing medical education activities. In addition to university-based programs, a statewide on-site education program was alluded to which is described in more detail here.

In 1971, recognizing that Florida physicians often cannot leave their area of clinical responsibility to travel to meetings for continuing education, we developed an on-site education program which would be responsive to the needs of physicians in individual Florida communities. The program, funded by the National Cancer Institute and, in cooperation with the American Cancer Society, allowed us to send (oncology) faculty members to community hospitals and medical societies to lecture on cancer topics at particular times designated by the requesting organization. In response to an announcement brochure mailed to individual members of the Florida Medical Association in 1971, the program was off to a modest start with seven different hospitals requesting programs. During that first year, 1971-72, a total of 19 programs were presented for an audience of 590 physicians (see table below). An approximate doubling of response was noted in the following year, 1972-73.

GROWTH OF A STATEWIDE ON-SITE CANCER EDUCATION PROGRAM

	1971-72	1972-73	1973-74	1974-75
ORGANIZATIONS	7	16	39	86
PROGRAMS	19	33	86	162
CREDIT HOURS	48	80	125	348
TOTAL AUDIENCE	590	1,620	2,709	8,101
HOURS COMPLETED*	1,770	4,680	8,292	25,716

*Credit Hours x Audience Count for Individual Programs totalled for the year.

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

In 1973-74 health professionals other than physicians, i.e., dentists, nurses, pharmacists, were also informed of the program and, in addition, brochures were mailed to education directors of all Florida hospitals, nursing homes, county medical societies and public health units. An increasing interest in cancer control coupled with mounting pressure on health professionals for participation in continuing medical education activities spurred the growth of the on-site program. Last year, 1974-75, 162 programs were presented for 86 different organizations in the state, furnishing 348 credit hours of continuing medical education for an audience of more than 8,000. Considering all parameters, organizations reached, programs presented, credit hours and audience numbers, the on-site cancer education program has undergone a 7-12 fold increase in activity in the four years of its existence, with continued growth anticipated this year in view of 200 programs already scheduled.

The success of the program, under the aegis of the Comprehensive Cancer Center for the State of Florida, may be attributed to the enthusiastic participation of more than 150 lecturing faculty from the University of Miami, the University of Florida and the University of South Florida, and to enthusiasm in the local community exemplified by representative comments: ". . . the program presented on early cancer detection included up-to-date material much valued by the practitioners of this community. Our predominantly retired, elderly population makes cancer therapy a major portion of all our practices . . ." and ". . . this program is reaching the grass roots of treatment and we have certainly seen some change in the attitude among the physicians in this area with the programs presented. . ."

While the purpose of the program is to reach as many Florida physicians and other health professionals as possible with an update in cancer control, the need for such a program is probably most crucial in areas removed from the larger metropolis. Since 53% of the requests for programs come from hospitals with less than 200 beds and 74% of the requests for programs come from health professionals in communities of less than 30,000 population, this program is obviously functioning as a true community outreach program.

Hopefully this on-site education program may serve as a model for continuing medical education in fields other than cancer.

▶ Dr. Papper, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

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The HL-A B27 Histocompatibility Antigen in Rheumatoid Arthritis Variants

Robert G. Gray, M.D., and Norman L. Gottlieb, M.D.

Abstract: Several inflammatory rheumatic disorders which commonly involve the axial skeleton have recently been associated with the histocompatibility antigen HL-A B27. The clinical manifestations of ankylosing spondylitis, Reiter's syndrome, psoriatic arthritis, and juvenile rheumatoid arthritis, and the relationship of the genetic marker HL-A B27 to these disorders are reviewed briefly. Histocompatibility antigen typing is a test of diagnostic value in differentiating inflammatory from degenerative or mechanical causes of back pain, especially early in the disease course or when the clinical picture is atypical.

The primary care physician frequently is involved in the initial evaluation, diagnosis and treatment of rheumatic diseases. His skills are required in the management of diverse conditions associated with back pain including inflammatory arthritis of the axial skeleton (sacroiliitis, spondylitis). Recently a histocompatibility antigen, HL-A B27 (formerly termed W27), has been associated with several rheumatic diseases which preferentially involve the axial skeleton, the "rheumatoid variants," including ankylosing spondylitis, Reiter's syndrome, psoriatic arthritis, and juvenile rheumatoid arthritis. In the past decade serologic definition of an individual's genetically determined and transmitted histocompatibility antigens has served as a major predictor of graft acceptance or rejection in organ transplantation. Study of the HL-A histocompatibility system also has led to the speculation that at least one rheumatic disease (Reiter's syndrome) may result from transmittal of an infectious agent to a genetically susceptible individual, as determined by HL-A phenotype.

The rheumatologic literature contains numerous reports suggesting that histocompatibility antigen typing is a significant, noninvasive addition to the various laboratory procedures employed in the differential diagnosis of back pain, and may provide clues to the etiology of, and interrelation between, these arthritides. The association between HL-A B27 and certain inflammatory rheumatic diseases associated with back pain, which may mimic various traumatic or degenerative low back syndromes, merits review.

The clinical features of these rheumatic diseases, and their relationship to HL-A B27, are discussed pointing out recent advances in the diagnosis and understanding of rheumatic diseases.

HL-A Histocompatibility Antigens

The major human histocompatibility system, designated HL-A (human leukocyte system A), is determined by a number of genes occupying a single large region on the sixth chromosome, the HL-A locus. The HL-A locus, in turn, consists of two major subregions (subloci) each of which controls a series of mutually exclusive antigenic specificities

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(designated segregant series A and B). Currently recognized HL-A antigens of the A and B series are indicated in Table I. Series at each sublocus (A or B) are inherited together as genetically linked pairs (codominant alleles). Thus, every individual inherits four HL-A antigens, one A pair and one B pair from each parent. HL-A antigens reside as proteins on the surface of all nucleated cells (e.g., lymphocytes) readily accessible to immune defenses and serve as the major mediator of graft rejection or acceptance, determining the degree of histocompatibility between donor organs and recipient immune systems. These antigens also may serve as genetic markers for inherited susceptibility to certain human diseases as seen in psoriasis where HL-A B13 and 17 antigens are found three times more than anticipated,[1] and in celiac disease and chronic active hepatitis where HL-A A1 and B8 are present three times more often than expected.[2, 3] HL-A B27, an antigen in the second segregant series (B), is present in approximately 8% of normal American whites, 4% of American blacks, 1% of Japanese, and is absent in African blacks.[4, 5] It is found as often in males as in females.

The most widely used method for HL-A typing is the lymphocyte microcytotoxicity technique in which the patient's lymphocytes extracted from heparinized blood are tested against an array of specific antisera to known HL-A antigens. Lymphocyte death constitutes a positive reaction. Further testing against other antisera continues until all four HL-A antigens on the lymphocyte surface have been identified.

Ankylosing Spondylitis

Ankylosing spondylitis is a chronic, frequently progressive arthritis of undetermined etiology which involves primarily the sacroiliac and spinal apophyseal (synovial) joints as well as the paravertebral soft tissues. Occasionally the peripheral and fibrocartilaginous joints, eyes, aortic valve and other structures also are affected. Onset typically is in the second and third decades of life with a male predominance of 10:1. Not uncommonly more than one family member is afflicted.

Table 1.—Currently Recognized HL-A Antigens.*

Segregant Series A	Segregant Series B
A1	B5
A2	B7
A3	B8
A7	B12
A10	B13
A11	B14
A28	B18
A29	B27
AW23	BW15
AW24	BW16
AW25	BW17
AW26	BW21
AW30	BW22
AW31	BW35
AW32	BW37
AW33	BW38
	BW39
	BW40

* W.H.O. committee on leukocyte nomenclature. Recently detected antigens are designated by a "W" (workshop) prefix. Each individual possesses two antigens derived from each segregant series (A and B).

The disease tends to develop insidiously with lumbosacral aching and stiffness and on occasion referred pain to the groin and buttocks. Sacroiliitis may cause pain in a sciatic distribution simulating mechanical or discogenic low back syndromes. Rarely sacroiliac joint inflammation may present with relatively acute, unilateral low back pain with fever and constitutional symptoms suggesting osteomyelitis. Bilateral sacroiliitis develops almost invariably and is associated with some restriction of lumbar mobility. Ossification of the annulus fibrosus of the intervertebral discs and adjacent connective tissue together with widespread syndesmophyte formation and apophyseal joint fusion may result in an immobile "bamboo" spine. Peripheral arthritis with predilection for the rhizomelic joints (hips and shoulders) may precede or follow onset of axial skeletal disease.

Iritis or iridocyclitis, occurring in 25% of patients, may be transient or progressive but with treatment rarely leads to significant visual impairment. Cardiovascular complications include conduction disturbances (most commonly, first-degree AV block) in 10%, and aortic valvulitis and insufficiency in approximately 3% of cases. Decreased chest expansion is a common finding and in severe cases may be associated with pulmonary insufficiency. Apical pulmonary fibrosis at times with cavitation has been reported.[6]

Schlosstein et al[7] in 1973 reported the results of HL-A typing in a large series of white patients with ankylosing spondylitis. HL-A B27 was present in 88% of 40 patients with ankylosing spondylitis compared with a 9% incidence in nonspondylitic controls. Almost simultaneously studies from England[8] and Canada[9] reported HL-A B27 was present in more than 95% of patients with ankylosing spondylitis and in 4% of normal controls. Approximately 25 other HL-A antigens were present with similar frequency in all patient groups. Approximately 50% of first-degree relatives possessed HL-A B27, a prevalence six times higher than in the normal nonrelated population.[8, 9]

Ankylosing spondylitis occurs infrequently in blacks and is reported rarely in black females.[10] Of

19 blacks with ankylosing spondylitis 89% were HL-A B27 positive[7, 11] and four of eight females also possessed the antigen.[12,13]

On the basis of existing reports gathered from both sides of the Atlantic, a strong association exists between the HL-A B27 antigen and ankylosing spondylitis patients and their first-degree relatives. The incidence of ankylosing spondylitis among Caucasians is estimated at 0.4% of males and 0.05% of females.[14] Consequently less than 8% of males and 1% of females possessing HL-A B27 will be expected to develop ankylosing spondylitis. If an individual is HL-A B27 positive, however, the risk of developing ankylosing spondylitis is at least ten times higher than in the overall population.

Recent evidence suggests that some stigmata of ankylosing spondylitis are detectable in a large portion of HL-A B27 positive individuals. In two studies,[15, 16] back pain was present in 28% of 96 healthy HL-A B27 positive individuals as contrasted with 10% of control groups. Sacroiliac abnormalities radiographically (sclerosis and/or erosions) were evident in a significantly higher proportion of HL-A B27 positive individuals (15 of 96) than those lacking the antigen (none of 96 matched controls). The prevalence of symptoms and x-ray findings suggestive of ankylosing spondylitis in HL-A B27 positive individuals was comparable in both sexes.[16] These preliminary findings suggest that undiagnosed ankylosing spondylitis may exist in 16% or greater of HL-A B27 positive subjects including females in whom the disease is uncommonly recognized.

Reiter's Syndrome

Reiter's syndrome is a systemic disease affecting the peripheral and axial skeletal joints and is associated with urethritis, ocular inflammation and a variety of mucocutaneous lesions including circinate balanitis, painless oral ulcers, onycholysis, and keratoderma blenorrhagia which may be clinically and histologically indistinguishable from pustular psoriasis. Elevation of synovial fluid complement may be a helpful diagnostic finding.[17] The syndrome often follows genitourinary or intestinal infection although any organ system may be involved long before others, and back pain may be the initial complaint. Most cases occur sporadically but epidemics have been reported in association with shigellosis. Reiter's syndrome is usually self-limited, persisting for six weeks to six months, but recurrences are common in the first two years. The affliction becomes chronic in a minority, occasionally evolving into axial skeletal disease indistinguishable from idiopathic ankylosing spondylitis.

Brewerton and associates[18] studied histocompatibility antigens in 33 Caucasian males with Reiter's syndrome. B27 was the only antigen present in greater than expected frequency, evident in 76% of patients with Reiter's syndrome compared with 9% of patients with nonspecific urethritis and 6% of normal controls. Of 12 patients with the classical Reiter's triad (arthritis, urethritis, conjunctivitis) 11 (92%) were HL-A B27 positive. Five patients with radiographic evidence of sacroiliitis and five other patients with spondylitis all possessed HL-A B27 antigen. Ten of 11 (91%) patients with anterior uveitis and 15 of 23 (65%) patients with peripheral arthritis, but without axial skeletal involvement, had HL-A B27.

Morris et al[19] tested for HL-A B27 antigen in 12 patients with gonococcal arthritis, 25 patients with Reiter's syndrome, six of whom had sacroiliitis or spondylitis, and 1,863 normal controls. All patients with gonococcal arthritis were HL-A B27 negative; 24 patients (96%) with Reiter's syndrome and only 8% of controls were B27 positive. Thus, HL-A B27 is a marker for Reiter's syndrome with or without axial skeleton involvement. In addition to the pathogenetic implications of these findings, HL-A antigen typing might aid in differentiating Reiter's syndrome from gonococcal arthritis in patients with urethritis and arthritis.

In 1963 nine of 602 men afflicted with dysentery developed Reiter's syndrome within 19 days of the onset of epidemic shipboard shigellosis.[20] More than a decade later[21] five of the nine patients were located and typed for histocompatibility antigens; four of the five were B27 positive. Based on prevalence of HL-A B27 in the normal population, 35 of the shigella-infected individuals would be expected to possess HL-A B27. Thus, following a single infective challenge, 12%-22% of susceptible subjects (i.e., those with B27) developed Reiter's syndrome. The single Reiter's patient without B27 demonstrates that with sufficient environmental challenge the disease may occur in the absence of known genetic susceptibility, or that other factors yet to be determined influence the development of Reiter's syndrome.

The strong association of Reiter's syndrome and ankylosing spondylitis with the HL-A B27 antigen suggests that both diseases may share a common etiologic factor, represent a dissimilar response to a given antigenic challenge, or are similarly genetically determined. HL-A B27 is not a marker solely for axial skeletal disease inasmuch as a high percentage of Reiter's patients with peripheral joint involvement alone were HL-A B27 positive.

Psoriatic Arthritis

Psoriatic arthritis characteristically is an asymmetric oligoarthritis with predilection for the distal interphalangeal joints and with involvement of the axial skeleton in approximately 20% of patients. As in ankylosing spondylitis, Reiter's syndrome and juvenile rheumatoid arthritis, pelvic periostitis, plantar fasciitis, and Achilles tendonitis may be features. Rheumatoid factor is not present in the serum. The disease may be clinically indistinguishable from seronegative rheumatoid arthritis in a minority of patients, psoriasis being minimal, and articular manifestations preceding dermatitis by many years.

In two small series[22, 23] HL-A B27 was found in more than 90% of patients with psoriatic sacroiliitis. Other studies[22, 24] detected the B27 antigen in one third to two thirds of patients with both peripheral and axial skeletal psoriatic arthritis. And, B27 was found in nearly one quarter of patients with peripheral arthritis alone compared to 6% of controls.

Juvenile Rheumatoid Arthritis

Juvenile rheumatoid arthritis (JRA) is an inflammatory rheumatic disease of childhood with varied patterns of presentation. In approximately half the patients onset is polyarticular similar to adult rheumatoid arthritis; in 30% only one or several joints are initially involved and in 20%, especially males, the disease begins with fever, constitutional symptoms, rash, and occasionally lymphadenopathy, splenomegaly and pericarditis, often without joint complaints. As with other rheumatoid variants, iridocyclitis may occur particularly in patients with monoarticular onset. Axial skeletal involvement not uncommonly is manifested by inflammatory synovitis of the cervical apophyseal joints. Additionally, sacroiliitis may be radiographically evident in 24% of patients[25] and in 45% of those with cervical involvement.[26] Sacroiliac x-ray changes may consist of fusion or erosions without sclerosis or may progress to the typical changes of adult ankylosing spondylitis.

Age at onset of the disease appears to be bimodal with peaks between the ages of one and three years and at nine years.[27] Nearly two thirds of patients will remit within a decade of onset. Serum rheumatoid factor is present in 10%-20% and antinuclear antibody in 13%.

In a cooperative study from Los Angeles and Taplow, England,[28] HL-A B27 was detected in 14 of 15 (93%) patients with JRA associated with sacroiliitis, only one of whom was female. HL-A B27 also was present in 20% of an additional 31 JRA patients without sacroiliitis or spondylitis during nine to 32 years of observation. Sturrock et al[29] found HL-A B27 in seven of 24 patients with JRA; six were males and had sacroiliitis radiographically. In another series[30] HL-A B27 was found in 42% of unselected subjects with JRA. B27 was associated with an earlier age of onset and was slightly more common in males in contrast to the usual female predominance (2:1) in JRA. None of the 11 patients with HL-A B27 had evidence of axial skeletal disease, an observation which may have been related to age at the time of examination.

The presence of HL-A B27 in 42% of patients with JRA and in 93% of those who developed sacroiliitis or spondylitis suggests that B27 may indicate susceptibility to JRA and may be of value in predicting axial skeletal involvement.

Discussion

All the rheumatoid variants share the absence of serum rheumatoid factor, the frequent presence of axial skeletal involvement in addition to peripheral joint affliction and a higher than anticipated incidence of uveal tract inflammation. Back pain may be an initial, early, or major complaint in all these disorders. Prior to development of typical radiographic abnormalities, differentiation between inflammatory and mechanical skeletal disease may be difficult in some cases.

Similar clinical features in the rheumatoid variants, such as uni or bilateral sacroiliitis, syndesmophyte formation, sausage digits, heel pain, dermatitis, and aortic valvulitis, have led to the speculation that a common etiologic factor(s) may be operative. HL-A B27 is one apparent common denominator in these disorders, and several hypotheses have been offered to explain this association.[13] HL-A B27 may be linked to an aberrant immune response (Ir) gene which determines susceptibility to a given disease. Alternatively, HL-A B27 and an unknown foreign (infectious) agent may share antigenic determinants resulting in failure of the host's immune system to respond appropriately to the stimulus (cross-tolerance). Lastly, the HL-A antigen itself may function as a cell membrane receptor for a specific virus or other agent.

It should be emphasized that although the association between HL-A B27 and the above rheumatic diseases is the strongest association yet identified, it is not invariably present in patients

with these illnesses and is present in 4% to 8% of the normal population. Therefore, it lacks specificity as a diagnostic test. It possesses a reasonably high degree of sensitivity in ankylosing spondylitis and Reiter's syndrome (90%), but false negative results occur more frequently in other rheumatic disorders, as shown in Table 2. Nevertheless, HL-A typing ultimately may further understanding of genetic susceptibility to infection or other causes of rheumatic diseases, aid in defining mild clinical expressions of certain arthritides, and may have prognostic value for the development of axial skeletal disease in Reiter's syndrome, psoriatic arthritis, and JRA. In patients presenting with back pain the presence of HL-A B27 may serve as a diagnostic tool in helping to distinguish early sacroiliitis or spondylitis from mechanical or degenerative afflictions of the spine.

Table 2.—Association Between HL-A B27 and Rheumatic Diseases.

Disease	HL-A B27 Per Cent Positive
Ankylosing Spondylitis	90-95
Reiter's Syndrome	75-95
Psoriatic Arthritis (with sacroiliitis)	70-90
Psoriatic Arthritis (without sacroiliitis)	25
Juvenile Rheumatoid Arthritis (with sacroiliitis)	95
Juvenile Rheumatoid Arthritis (without sacroiliitis)	20
Inflammatory Bowel Disease with Spondylitis[31,32]	60-75
Yersinia Enterocolitica Arthritis[33]	90
Normal Controls	5-10

References

1. Russell, T. J.; Schultes, L. M., and Kuban, D. J.: Histocompatibility (HL-A) Antigens Associated With Psoriasis, New England J. Med. 287:738-740, 1972.
2. Stokes, D. L.; Asquith, P.; Holmes, G. K. T.; MacKintosh, P., and Cooke, W. T.: Histocompatibility Antigens Associated With Adult Coeliac Disease, Lancet 2:162-164, 1972.
3. Falchuk, Z. M.; Rogentine, G. N., and Strober, W.: Predominance of Histocompatibility Antigen HL-A8 in Patients With Gluten-Sensitive Enteropathy, J. Clin. Invest. 51:1602-1616, 1972.
4. Albert, E. D.; Mickey, M. R., and Terasaki, P. I.: Genetics of the HL-A System in Four Populations: American Caucasians, Japanese Americans, American Negroes and Mexican Americans, In Fifth International Histocompatibility Workshop, Histocompatability Testing 1972. Edited by Dausset, J., and Colombani, J., Copenhagen, Munksgaard, 1973, pp. 233-240.
5. Mittal, K. K.; Hasegarva, T.; Mickey, M. R., et al.: Genetic Variation in the HL-A System Between Ainus, Japanese, and Caucasians. In Fifth International Histocompatibility Workshop, Histocompatibility Testing 1972. Edited by Dausset, J., and Colombani, J., Copenhagen, Munksgaard, 1973.
6. Appelrouth, D. and Gottlieb, N.L.: Pulmonary Manifestations of Ankylosing Spondylitis, J. Rheumatol. 2:446-453, 1975.
7. Schlosstein, L.; Terasaki, P. i.; Bluestone, R., and Pearson, C. M.: High Association of an HL-A Antigen W27 With Ankylosing Spondylitis, New England J. Med. 288:704-706, 1973.
8. Brewerton, D. A.; Caffrey, M.; Hart, F.; James, D. C. O.; Nicholls, A., and Sturrock, R. D.: Ankylosing Spondylitis and HL-A W27, Lancet 1:904-907, 1973.
9. Espinoza, L.; OH, J.; Kinsella, T.; Stacey, C. H.; Osterland, C. K., and Dove, F. B.: Ankylosing Spondylitis: Family Studies and HL-A W27 Antigen Distribution, J. Rheum. 1:254-259, 1974.
10. Baum, J. and Ziff, M.: The Rarity of Ankylosing Spondylitis in the Black Race, Arthritis Rheum. 14:12-18, 1971.
11. Lockshin, M.D.; Fotino, M.; Gough, W. M., and Litwin, S. D.: Ankylosing Spondylitis and HL-A; a Genetic Disease Plus? Am. J. Med. 58:695-703, 1975.
12. Swezey, R. L.; Zucker, L. M., and Terasaki, P. I.: Reduced Prevalence of HL-A Antigen W27 in Black Females With Ankylosing Spondylitis, J. Rheum. 1:260-262, 1974.
13. McDevitt, H. O. and Bodmer, W. F.: Histocompatibility Antigen, Immune Responsiveness and Susceptibility to Disease, Am. J. Med. 52:1-8, 1972.
14. Lawrence, J. S.: The Prevalence of Arthritis, British J. Clin. Pract. 17:699-705, 1963.
15. Cohen, L. M.; Mittal, K. K.; Schmid, F. R.; Rogers, L. F., and Cohen, K. L.: Spondylitis Stigmata in Apparently Healthy W27 Males, Arthritis Rheum. 18:392, 1975.
16. Calin, A. and Fries, J.: An Extraordinarily High Prevalence of Ankylosing Spondylitis (AS) in W27 Positive Males and Females; A Controlled Study, Arthritis Rheum. 18:390, 1975.
17. Pekin, T. J. Jr.; Malinin, T. I., and Zvaifler, N. J.: Unusual Synovial Fluid Findings in Reiter's Syndrome, Ann. Intern. Med. 66:677-684, 1967.
18. Brewerton, D. A.; Caffrey, M.; Nicholls, A.; Walters, D.; Oates, J. K., and James, D. C. O.: Reiter's Disease and HL-A 27, Lancet 2:996-998, 1973.
19. Morris, R.; Metzger, A. L.; Bluestone, R., and Terasaki, P. I.: HL-A W27 — A Clue to the Diagnosis and Pathogenesis of Reiter's Syndrome, New England J. Med. 290:554-556, 1974.
20. Noer, H. R.: An "Experimental" Epidemic of Reiter's Syndrome, J.A.M.A. 198:693-698, 1966.
21. Calin, A. and Fries, J. F.: Epidemic Reiter's Syndrome; Genetics and Environment, Arthritis Rheum. 18:390, 1975.
22. Brewerton, D. A.; Caffrey, M.; Nicholls, A.; Walters, D., and James, D.C.O.: HL-A 27 and Arthropathies Associated With Ulcerative Colitis and Psoriasis, Lancet 1:956-958, 1974.
23. McClusky, O. E.; Lordin, R. E., and Arnet, F. C., Jr.: HL-A 27 in Reiter's Syndrome and Psoriatic Arthritis; A Genetic Factor in Disease Susceptibility and Expression, J. Rheum. 1:263-268, 1974.
24. Metzger, A.; Morris, R. I.; Bluestone, R., and Terasaki, P. I.: HL-A W27 in Psoriatic Arthropathy, Arthritis Rheum. 18:111-115, 1975.
25. Carter, M. E.: Sacro-iliitis in Still's Disease, Ann. Rheum. Dis. 21:105-119, 1962.
26. Ansell, B. M. and Bywaters, E. G. L.: Proceedings Tenth International Congress Rheumatology, 2:241, 1961.
27. Sullivan, D. B.; Cassidy, J. T., and Petty, R. E.: Pathogenic Implications of Age of Onset in Juvenile Rheumatoid Arthritis, Arthritis Rheum. 18:251-255, 1975.
28. Edwards, J.; Morris, R. I.; Metzger, A. L.; Bluestone, R.; Terasaki, P. I.; Ansell, B. M., and Bywaters, E. G. L.: Follow-Up Study of Juvenile Chronic Polyarthritis With Particular Reference to Histocompatibility Antigen W27, Ann. Rheum. Dis. 33:289-292, 1974.
29. Sturrock, R. D.; Dick, H. M.; Henderson, N.; Goel, G. K.; Lee, P.; Dick, W. D., and Buchanan, W W.: Association of HL-A 27 and AJ in Juvenile Rheumatoid Arthritis and Ankylosing Spondylitis, J. Rheum. 1:269-273, 1974.
30. Rachelefsky, G. S.; Terasaki, P. I.; Katz, R., and Stiem, E. R.: Increased Prevalence of W27 in Juvenile Rheumatoid Arthritis, New England J. Med. 290-892-893, 1974.
31. Morris, R. I.; Metzger, A. L., and Bluestone, R.: HL-A W27 — A Useful Discriminator in the Arthropathies of Inflammatory Bowel Disease, New England J .Med. 290:1117-1119, 1974.
32. Amor, B.; Feldman, J. L.; Delbarre, F.; Hors, J; Beaujan, M., and Dausset, J.: HL-A antigen W27 — A Genetic Link Between Ankylosing Spondylitis and Reiter's Syndrome? New England J. Med. 290:572, 1974.
33. Kimmo, A.; Ahvonen, P.; Lassus, A.; Sievers, K., and Tiilikainen, A.: HL-A 27 in Reactive Arthritis: A Study of Yersinia Arthritis and Reiter's Disease, Arthritis Rheum. 17:521-526, 1974.

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(See next page for Editorial Comments)

EDITORIAL COMMENTS

This is a good paper, covering fairly well current information on B27 which is useful to physicians in most specialties.—Paul H. Bridgeford, M.D., St. Petersburg.

This article is an excellent review of the subject HL-A B27 Antigen and its role in the field of the rheumatic diseases and I would certainly recommend its acceptance. In fact, I would feel it worthwhile of publication in its entirety in any of the Rheumatology journals.—Louis M. Sales, M.D., Jacksonville

Well done. Should be of interest to many physicians.—Joseph G. Matthews, M.D., Orlando

The article is a timely review of literature on this interesting and novel topic.—Elia M. Ayoub, M.D., Gainesville.

Board of Family Practice Announces 1976 Examination Dates

The **American Board of Family Practice** has announced that its next certification examination will be given October 30-31, 1976, in seven U.S. cities.

Applications must be received by the Board office no later than June 15. They must be accompanied by a non-refundable application fee of $50.00. Applicants accepted for examination must also pay an examination fee of $300.00.

Information may be obtained by contacting: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, University of Kentucky Medical Center, Lexington, Kentucky 40506.

Cranio-Orbital Correction of Severe Facial Deformity
A New Horizon in Corrective Surgery

Mutaz B. Habal, M.D. and Jack E. Maniscalco, M.D.

Abstract: Recent advances, here and abroad, and indepth understanding of the problems related to the deformities in the craniofacial junction zone (cranio-orbital surgery), has resulted in the wide application of newer techniques for the correction of severe disorders in that region. Patients otherwise afflicted with such anomalies have always been termed inoperable and have not had the opportunity to develop as their peers. The face is the window of the patient to the outside world. It is important to have as minimal deformities as possible during the developmental period of the pediatric patient with facial deformities. Such deformities in early life may precipitate behavioral and psychosocial problems if not attended to. It is the right of every human being to look human.

The past decade has witnessed a giant leap forward in treatment of patients with severe facial abnormalities. The operative treatment was introduced and reached new perspective through collaboration of the various allied health fields. This new approach arose from the interweaving between the specialties of plastic surgery and neurosurgery. The newly developing field of craniofacial surgery, in which two surgeons participate side by side performing an operative procedure in the most dangerous and complex part of the face, has been brought into perspective. The pioneering work is accredited to Tessier,[1] Converse[1] and Murray.[2] This new approach has helped many children left unattended, termed hopeless and confined in mental retardation institutions, to live out the rest of their lives.

The Rationale

We became acquainted with the craniofacial approach while treating patients with large, unresectable tumors. Such patients were termed inoperable by standard surgical criteria of limited resection, radiation therapy, as well as chemotherapy, which were instituted to no avail. Then through collaboration of the plastic surgeon and neurosurgeon, we found that such tumors, along with some of the adjacent craniofacial bones, were resectable. The patients termed hopeless by most standards were, after craniofacial resection, completely cured of their tumor.[3, 5] Experience paved the road to corrective craniofacial surgery. The approach was then directed toward patients with severe malformation syndromes such as craniofacial dysostosis, frontonasal dysplasia, Treacher-Collins, and hemifacial microsomia. A whole new horizon was opened for such children to undergo a combined craniofacial approach for severe facial malformations. These patients are no longer confined to mental retardation institutions, particularly since 80% to 90% of those with craniofacial developmental disorders have normal mental development and normal intelligence.

The Center Concept

At the present time such new and complex operations are performed in a few centers where multiple medical specialties and superb facilities are available. This opinion is also shared by others who have been involved in craniofacial repairs.[1] The basic requirements for the formation of such centers are as follows:

1. **THE TEAM**—The organization of a craniofacial team is one of the main tasks the surgeon must undertake in order to reiterate and interconnect the various involved health specialties. The head region, as viewed by various physicians with diversified interests, must be brought into focus, centering on one point. The plastic surgeon, neurosurgeon, otolaryngologist, and ophthalmologist must concentrate their efforts in an organized way toward correction of a multifaceted problem. The help of the pediatrician in the care of such patients is of utmost importance. Allied medical personnel are also required, such as orthodontists, psychologists, social workers, and speech therapists. Organization of such team concepts should also involve geneticists interested in craniofacial malformations to

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evaluate the patients and counsel the families. The team will include an operating group as well as a group to evaluate, measure, check and document the abnormalities and changes which may ensue after treatment.

2. **THE EVALUATION AND PLAN**—A complete preoperative work-up should include a thorough evaluation by members of the team in order to assess the various parameters which may be present, absent or deficient in each particular region, i.e., orbital, maxillary and cranial. Cephalographic measurements and documentation are performed utilizing tomograms of the craniofacial bones. The team then meets and a preoperative plan is introduced by the operating surgeons. This plan is then discussed for validity and prognostic value on the basis of each individual patient.

3. **THE OPERATION**—The operative approach involves complex, prolonged, and delicate surgery. The approach can be facilitated by an anesthesiologist well versed in administration of anesthesia to children as well as being familiar with neurosurgical problems. The anesthesiologist can aid tremendously in decreasing the intraoperative mortality as well as facilitating intracranial exposure during these procedures. The surgeon may advise, after a suitable period, a small touch-up operation (secondary operation) to be done in order to improve particular aspects of the major corrective procedure. Frequently the nose will require several minor corrections before the final and definitive result is obtained (Fig. 1).

4. **THE ACHIEVEMENTS**—The gain from craniofacial corrective surgery is equally distributed between these categories: (a) psychosocial adjustment after acceptance; (b) physiologic improvement in vision, hearing, and speech, and (c) cosmetic improvement—self concept.

The psychosocial activities and behavioral patterns of each child are studied in depth by the social worker and psychologist.

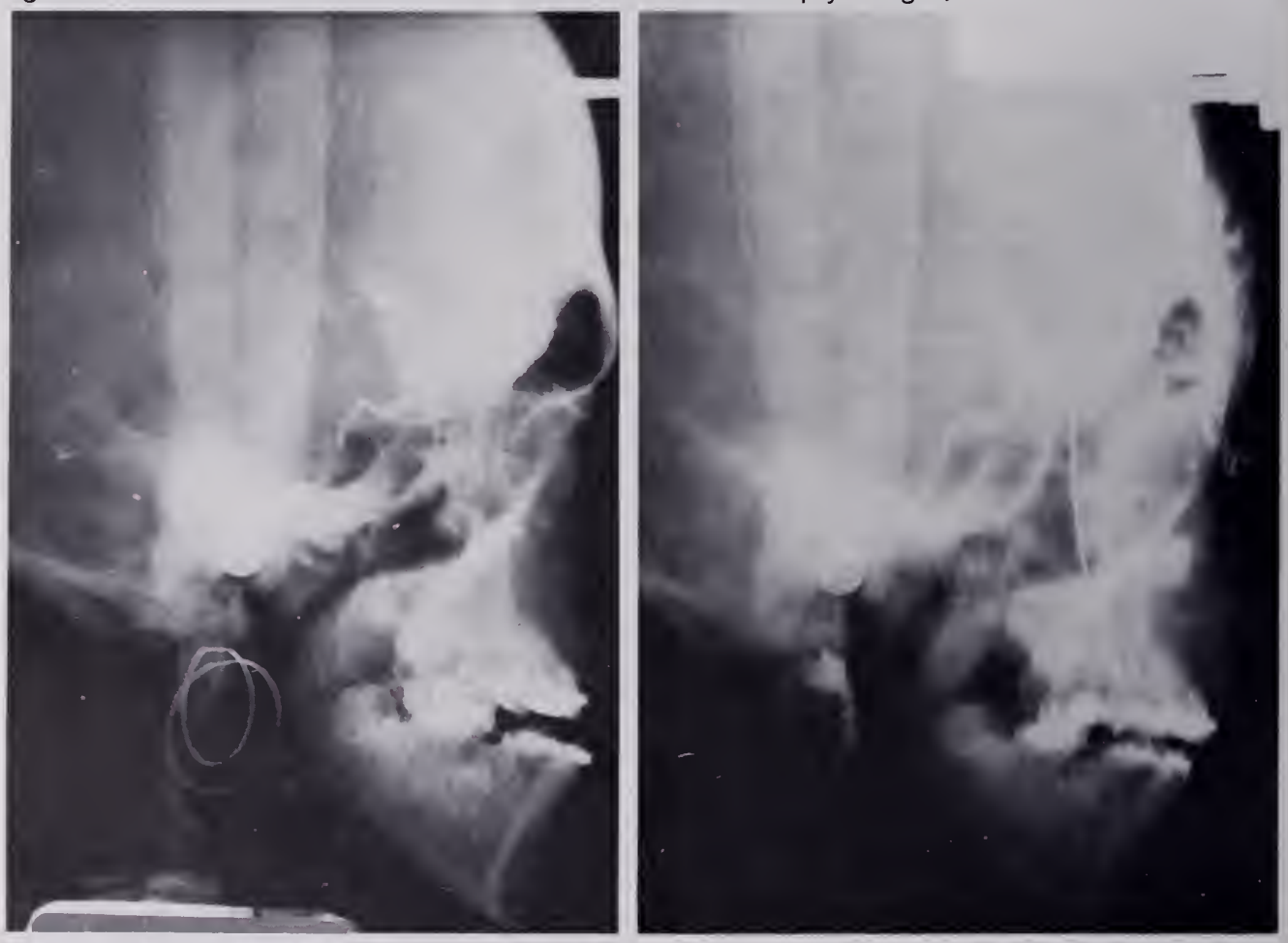


Fig. 1.—Pre- and postoperative lateral x-ray of a patient with Crouzon's disease. Note the class III malocclusion in the preoperative x-ray and the correction after a high LeFort III osteotomy. Notice the wires used for internal fixation in order to maintain the appropriate osteotomized segments in place, in addition to bone graft augmentation after repositioning.

5. **COMPLICATIONS** — Major complications which may arise immediately during or after the procedure are related to the central nervous system. The most important is acute swelling of the brain (malignant cerebral edema). This has been minimized at our institution with the appropriate approach and with the experience gained during the last five years. Spinal drainage is very important in order to keep the brain soft during and after the operative procedure. The spinal catheter drainage intraoperatively enhances the operative exposure and also provides for postoperative monitoring of intracranial pressure. Due to prolonged retraction on the brain, and sometimes because of decreasing size of the cranial vault, postoperative edema is a serious, threatening and life-endangering problem. In an effort to minimize the rebound swelling problem that may occur in the brain, the use of Mannitol and other diuretic agents should be avoided, if possible. Utilizing spinal catheter drainage, as well as hyperventilation and the reverse Trendelenburg position on the operating table, we have found surgical exposure more than adequate. With these maneuvers we found it unnecessary to dehydrate the brain with diuretics during or after the corrective procedure.

Clinical Experience

In the past four years we have performed over 35 corrective procedures on children with deformities related particularly to the orbit. Examples are hypertelorism, exorbitism, and orbital dystopia. All the patients had combined cranio-orbital correction and all necessitated the use of autogenous bone grafts to augment or fill the gap created by repositioning the controlled osteotomized osseous segments. We have had no mortalities. We had two morbidities early in our series related to acute brain swelling that were treated with corticosteroids and prolonged spinal catheter drainage. There was no major morbidity or permanent deficit related to this complication. There is no need to use antiepileptic



Fig. 2A.—A preoperative photograph of the patient with severe facial deformity. Note the class III malocclusion, exorbitism, and absence of facial balance. Fig. 2B.—Postoperative view of the same patient with the complete correction of the deformity. The patient fits into the second category of dysostosis of the craniofacial bones. Note complete correction of the exorbitism, the class III malocclusion and notice the absence of facial scarring. This operative procedure was done through the four concealed incision sites and no apparent scarring was left on the patient's face.



Fig. 3.—Pre- and postoperative photographs of a patient with orbital hypertelorism (teleorbitism). Note the balance of the orbit and correction of the exotropia after the rotation of the orbits 23 mm toward the midline (horizontal and saggital movements).

drugs in the patients, since the dura is not usually opened.

Prospects for the Future

Children with severe craniofacial deformities should first be sent to the appropriate team for consultation. A small minor operative procedure or "camouflage surgery" should be completely avoided. Most of the time, we are able to correct these deformities with concealed incisions,[4] therefore, any additional scarring from minor procedures may interfere with the final and definitive repair of the facial deformities. A complete diagnostic work-up is performed and appropriate consultations and counselling are pursued. The parents and patients are advised of the appropriate operative procedure. Interestingly, behavioral and psychosocial abnormalities that may precede surgery are usually corrected following surgery and appropriate psychological counselling. The patient is of cognizant age. His parents should understand these points thoroughly.

In the future, with better understanding of the timing, complexity, and expenses involved in such corrective procedures, we hope to minimize the problems to the point where such procedures can be done in every local medical center. At the present time, we feel that such an approach is in its infancy. We should look forward to its development and expansion in such a way as we did to open heart surgery in the early 1960's and renal transplantation in the late 1960's. We should also be looking forward to having precise predictive values for all the corrective procedures on both growth and behavior, in order to be in a better position to advise the parents and be precise in directing their expectations with facts.

In summary, a new approach has been in the forefront for the past six years for correction of severe facial deformities. This approach is now well accepted in a very few medical centers around the world. Children that have had cranio-orbital corrective surgery early in life have experienced marked improvement in behavioral and emotional disturbances. Ideally, such procedures should be done prior to school age to minimize the potential of permanent psychosocial scarring. We should be very careful not to produce any further disfigurement or scarring. Our efforts have been directed towards improving the outlook. The "team approach" must be well stressed. Complete diagnostic and prognostic parameters should always be implemented. The solo, unprecedented, and impetuous approach should be condemned.

References

1. Epstein, F. J., et al: Radical One State Correction of Craniofacial Anomalies, J. Neurosurg. 42:522, 1975.
2. Murray, J. E.; Swanson, L. T.; Cohen, M., and Habal, M. B.: Correction of Midfacial Deformities, Surg. Clin. North America 51:341, 1971.
3. Murray, J. E.; Matson, D. D.; Habal, M. B., and Geelhoed, G. W.: Regional Cranio-Orbital Research for Recurrent Tumors with Delayed Reconstruction, Surg., Gynec. & Obst. 134:437, 1972.
4. Habal, M. B., and Chaset, R. B.: Infraciliary Transconjunctival Approach to Orbital Floor for Correction of Traumatic Lesions, Surg., Gynec. & Obst. 139:420, 1974.
5. Habal, M. B., et al: Combined Cervical Posterior-Anterior Approach to Spinal Foramen Tumors, J. Neurosurg. 37:113, 1972.

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Treatment of Infected Cardiac Pacemaker Site With Closed Irrigation Report of Case and Subject Review

Osvaldo Contarini, M.D. and R. Daley Goff Jr., M.D.

Abstract: The interruption of a pacemaker's function by the complication of infection is a serious hazard.

It is accepted practice to treat infected pacemaker sites either conservatively or with complete removal of the pacemaker and insertion of a new one.

Conservative treatment includes (a) serial irrigations with delayed secondary closure, (b) debridement and sterilization of the battery and its site, and (c) revision of the pacer's site and closed irrigation.

A case of successful treatment of an infected pacemaker pocket with closed irrigation and without interruption of its function is reported.

Improved techniques of construction and implantation have established the effectiveness of pacemakers for treatment of symptomatic bradyarrhythmias unresponsive to medical treatment. Infection continues to be a serious complicating problem despite widespread use of "prophylactic antibiotics."

At the University Hospital of Jacksonville two patients (3.9%) suffered infection of the pacemaker site during the past five years. Incidence of this complication ranges from 1.8% to 12:5% in various reports.[1,2]

The traditional method of treatment entails complete removal of the pacemaker, temporary external transvenous pacing, antibiotic treatment to eradicate infection, and implantation of a new permanent pacemaker at a different site after all infection has subsided.[2-5] Occasionally the second pacemaker is implanted at the time the first one is removed.

Three types of conservative treatment have been used with good results.

The first is described by Dargan et al[6] and Furman[7] in which debridement of the infected area under local anesthesia is followed by serial open irrigation with solutions of antibiotics. Delayed closure of the wound with stainless steel wire is performed after eradication of the infection. Furman utilized this method in several patients but believes that the procedure has a high percentage of failure.

In 1972 Bonchek described three cases of extruded and infected pacemakers successfully treated with extensive debridement under local anesthesia, and sterilization of the battery and pacer site with an antibiotic solution.[8] Enlargement of the pocket permitted primary closure without tension. Parenteral antibiotic treatment was continued for one week.

Plastic surgeons have contributed to solution of the problem of wide debridement with addition of a mobilized skin flap as reported by Coburn et al in 1972.[9]

A third method of conservative therapy was described by Furman et al in 1972[10] and by Golden et al in 1973[1] with some technical modifications. It is based upon antibiotic treatment pre- and postoperatively and closed irrigation with antibiotic solution after debridement. Furman, after local wound debridement and irrigation with sterile saline, closed the wound primarily and inserted percutaneously a #17 gauge polyethylene catheter into the pocket. In its most dependent part, he placed a Penrose drain to evacuate the antibiotic solutions used for irrigation drainage the next three days. Golden and his associates made use of a #14 Fr. sump drain connected to constant suction in the most dependent part of the pocket and two #14 Fr. red rubber catheters inserted into the upper part of the pocket through which the irrigation fluid was inserted. The irrigation was continued for one week along with systemic antibiotic treatment.

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Case Report

A 70-year-old obese Black female with mild hyperglycemia was admitted to the Medical Department of the University Hospital of Jacksonville because of severe, symptomatic bradyarrhythmia. After being paced with a temporary transvenous pacemaker for several days, she was transferred to the Thoracic Surgery Service and underwent insertion of a permament cardiac pacemaker through the right cephalic vein with the battery being buried in a pocket below the right pectoralis major muscle.

Five days after insertion a hematoma of the pocket was first aspirated and then drained in the lower part of the incision. This ultimately became infected and a culture revealed Staphylococcus aureus sensitive to sodium oxacillin.

The patient was treated with oral administration of 500 mg sodium oxacillin every six hours. On the same day under local anesthesia the pocket was opened along the previous incision for about 3 cm and irrigated profusely with normal saline and Betadine solution. A precut Veno-Tube was inserted in the upper part of the pocket through a small stabwound and connected to an IV bottle containing 500 cc NS plus 1 gm sodium oxacillin to run 30 cc per hour.

A Hemovac tube was brought through the skin from the most dependent part of the pocket and connected to a vacuum bag. The pocket was debrided and closed primarily with interrupted sutures of 3-0 nylon.

The irrigation was continued for eight days followed by a three day period of intermittent irrigation with 1 gm sodium oxacillin every six hours. The duration of irrigation was guided by culture from the Hemovac bag that was left one day after removal of the upper tube.

The patient was discharged after 13 days with functioning pacemaker and the infection controlled. After five months there was no evidence of recurrence.

The rationale of the traditional method of treatment of infected pacemaker sites is that all foreign material must be removed, and that the infection may extend from the battery pocket along the track of the electrode.

When feasible, however, a conservative approach should be attempted. Of all methods of conservative treatment, the closed irrigation appears to offer the best results. Revision and enlargement of the pocket are suggested only in case of decreased vitality of the skin flaps.

Choice of the solution for irrigation is based upon the antibiotic sensitivity of the cultured bacteria and is initially guided by a Gram stain. The duration of irrigation depends essentially on the negativity of the culture from the drained fluid. The Hemovac tube should be removed at least one day after the irrigation tube unless drainage persists.

We believe that this complication can be avoided with careful surgical technique, including deep implantation of the battery and meticulous hemostasis. Prophylactic antibiotic treatment is generally employed. Early recognition of hematomas with appropriate evacuation and wound care may avoid the unnecessary loss of a pacemaker.

We realize, certainly, that each patient with an infected pacemaker site may require a different therapeutic approach, dictated by the conditions of the patient as well as by causative and local factors, but we have been pleased by the effectiveness and simplicity of the closed irrigation technique.

Since this paper was submitted for publication, we have had the occasion to use this procedure on another patient with success.

References

1. Golden, T. G.; Lovett, L. W.; Harrah, D. G.; Wellons, A. H., and Nolan, P. S.: Treatment of Extruded and Infected Permanent Cardiac Pulse Generators; Application of Technique of Closed Irrigation, Surgery 74:575-579 (Oct) 1973.
2. Firor, B. W.; Lopez, F. J.; Nanson, M. E., and Mori, M.: Clinical Management of Infected Pacemaker, Ann. Thor. Surg. 6:431-436 (Nov.) 1968.
3. Imparato, M. A. and Kim, E. G.: Electrode Complications in Patients with Permanent Cardiac Pacemakers, Arch. Surg. 105:705-710 (Nov.) 1972.
4. Smith, M. D. and Nicholas, P. D.: Cardiac Pacemaking, Ann. Thor. Surg. 8:166-190 (Aug.) 1969.
5. Schwartz, E.; Crastanopol, P., and Hamby, R.: Catheter Extruslon with Infection Complicating Permanent Endocardial Pacing, Chest 54:514-517, 1968.
6. Dargan, L. E. and Norman, C. J.: Conservative Management of Infected Pacemaker Pulse Generator Sites, Ann. Thor. Surg. 12:297-299 (Sept.) 1971.
7. Furman, S.: Correspondence. Ann. Thor. Surg. 14:328-329 (Sept.) 1972.
8. Bonchek, I. L.: New Methods in Management of Extruded and Infected Cardiac Pacemakers, Ann. Surg. 176:686-689 (Nov.) 1972.
9. Coburn, J. R. et al: Covering an Exposed Pacemaker, Plast. Reconst. Surg. 50:622-624 (Dec.) 1972.
10. Furman, W. R.; Hiller, J. A.; Playforth, H. R.; Bryant, R. L., and Trinkle, K. J.: Infected Permanent Cardiac Pacemaker, Ann. Thor. Surg. 14:54-58 (July) 1972.

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EDITORIAL COMMENT

I believe this paper is well written and concise. It is of importance since it re-enforces a known method of treatment of a difficult problem. This simple approach may become progressively more important as the number of cases (and infections) increase. — Banning G. Lary, M.D., Miami.



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SPECIAL ARTICLES

Community Mental Health Centers Or Is There a Better Way?

Philip B. Phillips, M.D. and Roswitha B. Fischer, M.A.

Abstract: The Community Mental Health Center Act was intended to provide a greater accessibility to psychiatric care for people needing such treatment, primarily people who were indigent or not able to obtain private care.

The burgeoning of these centers, often inadequately staffed by psychiatrists, has led to a lowering of the standards of professional care. Generally, the psychologists and social workers who man these many centers feel more effective in dealing with the nonpsychotic "client" since such persons fall more properly within their domain. As new programs, approaches, and methods develop the focus seems to be shifting from the sick indigent psychiatric "patient" to the inadequate, uneducated, and unemployed on the one hand, and the verbal, educated, attractive, but unhappy on the other hand. Some clinics are reported as becoming more interested in the "paying patient" to help meet their budgeting needs.

Social problems, behavior inadequacies, learning difficulties and marital disharmony are all worthy of human assistance but may not require the specialized talents of the psychiatrist and his psychopharmaceutical agents. For this and other reasons perhaps a new approach should be taken. Psychiatrists and their associates might treat the indigent patients privately under a subsidized program and the psychologists and social workers devote their full efforts at the centers toward whatever help they can be to the "clients" who do not need the special skills of the psychiatrist.

The paper is a personal opinion of the authors and offered as an approach possibly worth serious consideration.

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The topsy-turvy growth of Mental Health Centers lavishly funded by tax dollars from multiple sources, their spread into social problem areas, the extremely high costs of services rendered and their increasing focus on the paying patient, private and/or insured, make necessary a second look. Are they the answer to providing proper care to the indigent mentally ill or could a better way be developed?

New Era in Mental Health Care

The Pennsylvania Hospital established in 1752 in Philadelphia was the first establishment catering to the sick in the English colonies. Until the end of the 19th century such care as was provided psychiatric patients consisted primarily in food, shelter, protection and some medical attention.

Eminent men of science such as Kraepelin, Bleuler, Freud, and Jung in western Europe, and Bekhterev, Korsakov and Pavlov in Russia contributed gradually to a new era in mental health care with advances both in psychological theory and in psychiatric practice. After World War II the profession and later the public recognized the need for improvement in available mental health care through expanded facilities and broadened training opportunities. The postwar popularity of psychoanalytic concepts and practices gave way in the '60s to an emphasis on psychopharmacology and a burgeoning of assorted schools of thought in psychology. The rapid appearance of effective new pharmaceuticals made expanded outpatient programs feasible and reduced society's dependence on large mental hospitals. In order to provide needed care for the indigent and less fortunate who suffered mental illness President Kennedy urged a new type of health facility based on comprehensiveness, coordination and continuity and these points were identified in the Federal Act which resulted.

While psychiatric units in general hospitals gradually increased in the two decades following World War II it was not until the mid-'60s that the Community Mental Health Centers mushroomed. From 240 such centers in 1970 the total climbed to 505 in March 1975 and 86 more have been approved for the coming year. These Community Mental Health Centers receive some 30% to 40% of their support from federal funds, 30% from state funds, 10% from local government and the remainder from fees for service and third party payments. While some 40,000 individuals work in Mental Health Centers only 6% of these are psychiatrists and many of them are in administrative positions spending relatively little time with patients.

As Mental Health Centers have tried to absorb the flood of young psychologists and social workers pouring out from our universities they have, almost of necessity, developed many new areas in which to utilize these people. The basic goal of providing effective psychopharmaceutical treatment and psychotherapy for the mentally ill seems to have become relatively less important as program developers looked for new areas of social conflict to serve. These social and community needs are real and worthy projects but expensive, and there seems to be no end to their growth. Young parents are taught to be parents, ill-mannered children are counseled to behave, the inept are taught social skills and delinquents are seen in individual and group therapy hoping to quell their antisocial rebellion. Drug abusers are provided some degree of love and support and hopefully understanding. Special programs are set up for alcoholics under the popularized assumption that the abuse of alcohol is a "disease." Drying out centers, group counseling activities and various recreational and amusement facilities are provided to assist these victims of their own personality limitations and character deficiencies. Marriage counseling is offered the distraught spouses and unhappy mates who seek consolation and help in their explosive unions. Learning disabilities of all sorts in all ages are provided separate programs of assistance. Day care centers offer partial hospitalization for persons whose days are otherwise dull and unrewarding and who need resocialization, to learn interpersonal skills in getting along with others, and how to go about seeking employment compatible with their limitations.

The list of special sections, services, programs, halfway houses, friendship houses, resident houses, and detoxification units is almost endless. This is not to say that these services are unnecessary, but their role in prevention or treatment of mental illness is distant at best. Many problems historically handled by parents, pastors, school authorities, scouting, boys clubs, athletic programs, and the courts now seem to be the concern of Community Mental Health Centers. Staff personnel are assigned to man "hot lines," to answer "crisis calls," and to deal with all sorts of social emergencies. This dependency on government agencies seems reflective of the trend of the American public which has lost its self-reliance and looks to "big brother" for solutions. In these centers which try to be everything to everybody one encounters various psychological schools of thought, theories, trends, therapeutic orientations and innovations. Available services are offered both individuals and groups and involve most of the new fads coming out of the university graduate schools. Somewhere within this vast conglomerate of services the psychiatric outpatient hopefully receives the necessary psychotherapy and medication. Since psychotrophic drugs have shortened the duration of hospitalization and reduced the relative importance of institutional care for the chronic mentally ill patient his return to and maintenance within the community must be a major component in the planning and provision of any successful treatment program.

In our local area psychiatric admissions to general hospital units reflect that 75% of the admission of indigent patients are actually readmissions due generally to failure to take prescribed medication. Since the "Baker Act" provides only two weeks local hospitalization it is necessary to send more than half of these patients on to the state hospital for longer term care. We must, therefore, as psychiatrists and taxpayers ask ourselves seriously whether the present Mental Health Center system which provides treatment for the indigent is not conducive to recidivism. Does it not actually promote the patient's failure to continue outpatient treatment so vitally necessary if he is to remain well?

The type of patient, his illness, and his environment must all be considered if an effective maintenance treatment program is to be provided. The psychiatric patients for whom the Mental Health Centers were originally planned generally belong to the lowest income groups and prior to the program were seriously neglected. Their backgrounds show an average fourth to sixth grade education with their occupational potential seldom exceeding the level of unskilled or semiskilled labor. Thus they seem doomed to remain in one social class and confined to move within its limits. For fear of being recog-

nized as mentally ill and therefore considered a pariah by friends and neighbors a chronic schizophrenic tends to conceal his true feelings and/or his symptoms whenever possible. Often his limited literacy prevents his gaining any insight into his illness or clearly understanding the necessity of continued medication and treatment. Many patients of this social level are reluctant to continue medication and are supported in their reluctance by friends and relatives who discourage any dependence on drugs feeling that such continued medication represents the taking of "dope." Some families are hostile toward the patient and his illness and tend to deny its existence. Hospitalization and psychiatric treatment is initiated by the family only when the disturbance by the patient has reached unmanageable proportions and his illness interferes with the routine of family life. Indigent patients are often socially less mobile and tend to remain in particular neighborhoods where they feel secure. General medical services are usually provided by city or county hospitals, but psychiatric services may not be available there. Hence a psychiatric patient has to make transportation arrangements, go to a Mental Health Center, face strangers and he may not be able to pay the small fees required. Many patients thus conveniently forget their appointments and their medication. If small satellite clinics were established centrally within specific neighborhoods to provide more accessible treatment they would probably be open only a few days a week and this relative inaccessibility would deny a patient the opportunity to call on his physician when difficulties occurred and would therefore not provide him the reassurance of being taken care of. A better way than the Mental Health Center must thus be found.

Proposed Program

Studies have shown that the "per-client-contact" cost in a Mental Health Center may range from $50 to $100 whereas private psychiatric fees for an average patient visit (15 minutes to one hour) range from $15 to $60. The productivity per staff person, i.e., the patients seen per day, seems much less than in private practice. The continuing growth of special programs of help with the problems of living has made the real psychiatric patients almost a minor group. Changes are proposed which would reduce costs, improve care and assist in closer supervision of those really needing treatment through separating "patients" (those with schizophrenia and psychotic or neurotic depression) from "clients." Having the patient treated by private psychiatrists and their own staff associates, the treatment would be administered within a medical setting (a physician's office), separated from all the other helpful but nonmedical services which Mental Health Centers offer. Indigent patients could be seen more frequently, be provided more individualized care and be reached more successfully by their psychiatrist and his associates. One or more related professionals such as a psychologist, psychiatric nurse or social worker might be employed to assist in dealing with the additional case load of subsidized indigent patients and assist the psychiatric patient with his related social problems. Yet, this would be a small team more permanent and ultimately more familiar to and with the patient. Such a team could maintain close continuing contact with the local Vocational Rehabilitation office, a "government agency" with an outstanding record of accomplishment as an economical responsible and worthy "crutch" to those in time of need. Centers would continue to provide for the great mass of clients whose problems include learning difficulties, personality inadequacies, a lack of social skills, the manifestations of behavior irregularities, and those persons with marital discord and the other human vicissitudes not really requiring medical psychiatric training or pharmacotherapy.

Private psychiatrists, if assured of third party payment for their services, could expand their own staff modestly with the necessary professionals and supporting clerical personnel and provide the indigent psychiatric patients a level of private care comparable to that provided the average middle or upper class patient. Many patients have indicated a preference for this personal attention. They would feel that they had a physician of their own and would presumably be much more likely to continue the required medication. The cost should be appreciably lower due to less time being wasted in the innumerable and often unnecessary conferences seemingly standard in large clinics, the usual light work loads, and the general inefficiency of overpopulated and overstaffed public agencies. "Patients" could at times be referred by their psychiatrist to become "clients" of Halfway Houses or Day Care Centers if the Mental Health Center had such facilities, whenever such affiliations seemed feasible or helpful to the patient. A real asset in the rehabilitation of the improving psychiatric patient is the provision of the Halfway House where a tolerant and supportive milieu is provided those not quite ready to face the world alone. The psychotropic drugs and the continued care of the psychiatrist which together

offer the greatest boon to the patient are properly supported by these Halfway Houses. Some Day Care Centers also serve a useful purpose and justify their expense. There is a high therapeutic potential with this combination of resources: psychotropic drugs, psychiatric care, Halfway House, Day Care Center, general hospital psychiatric unit or private psychiatric hospital, and when required, the longer term care of the state or veteran's administration hospital. It is regrettable to see the government displace the treatable mentally ill patient to a low priority and vote huge sums of money in support of such low-yield programs as Drug Abuse Centers and alcohol programs. If tax funds are to be expended in a public mental health program should they not be focused on those people who suffer an illness and disability through no fault of their own, and who can with help be given a chance at a normal life? Pathetic are the drug abusers whose antisocial drives have led to their drug dependence and whose recidivism rate is so deplorably high, but of questionable public health investment as are so many of the alcoholics. These quit their alcohol addiction only when their life or survival is really threatened and when they still have awareness enough to care. Many, of course, do not survive; continuing their heavy drinking regardless of the consequences. A drug abuser or an alcoholic who really wants help can get it but the high failure rate in most programs is because the "patients" don't seem to care or don't really want to quit. A psychiatric patient can be helped in his schizophrenic illness or his depression by psychopharmaceuticals even if in his illness he doesn't think he wants or needs help.

A secondary benefit to the clientele from such a restructuring of Mental Health Center services would be the gradual differentiation of those who are truly psychiatric "patients" in need of the medical psychiatric care and those "clients" who seek help with problems and difficulties in living which are not really mental illness but rather are everyday social needs which have unfortunately been subsumed under the mantle spread generously by overly zealous psychiatrists too willing to acknowledge expertise in other fields. As a result insurance companies might have a "pilot study" in operation which would enable them, and National Health Insurance, whatever form it finally takes, to make that important delineation between the actually sick and the socially maladapted or potentially sick, a decision long awaited if our sick are to be covered fairly and adequately by a realistic insurance program.

Bibliography

Bryant, C. A.: The Puerto Rican Mental Health Unit, Psychiat. Annals 5:8, 333-338, 1975.

Carroo, A. E.: A Black Community in Limbo, Psychiat. Annals 5:8, 320-323, 1975.

Curtis, R. W.: Team Problem Solving in a Social Network, Psychiat. Annals 4:12, 12-27, 1974.

Glasscote, R.: The Future of the Community Mental Health Center, Psychiat. Annals 5:9, 382-388, 1975.

Huessy, R. H.: Some Historical Antecedents of Current American Mental Health Dilemmas, Psychiat. Annals 4:12, 31-39, 1974.

Johnson, J. C.: The Future of Psychiatry in General Hospitals, Psychiat. Annals 5:9, 368-374, 1975.

Lamb, R. H.: Helping the Long-Term Schizophrenic, Psychiat. Annals 5:7, 279-285, 1975.

Lefley, H. P.: Approaches to Community Mental Health: The Miami Model, Psychiat. Annals 5:8, 315-319, 1975.

Macht, L. B.: Neighborhood Psychiatry, Psychiat. Annals 4:9, 43-55, 1974.

Macht, L. B.: Beyond the Mental Health Center: Planning for a Community of Neighborhoods, Psychiat. Annals 5:7, 279-285, 1975.

Sandoval, M. C. and Tozo, L.: An Emergent Cuban Community, Psychiat. Annals 5:8, 324-332, 1975.

Stone, A. A.: The Right to Treatment and the Psychiatric Establishment, Psychiat. Annals 4:9, 21-42, 1974.

Sussex, J. N. and Weidman, H. H.: Toward Responsiveness in Mental Health Care, Psychiat. Annals 5:8, 306-311, 1975.

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EDITORIAL COMMENTS

This paper is on a very timely subject which is highly pertinent to citizens and taxpayers as well as physicians and I heartily endorse its publication. — Daniel S. Hellman, M.D., St. Petersburg.

This is an excellent paper. My only criticism is his rejecting alcoholism and drug abuse as having underlying emotional illnesses which, in my opinion, is so. Mental health centers are spending much more than they should per patient or "client visit" and often on inadequately trained personnel. This paper is thought provoking and will prove stimulating to a number of us in the field of psychiatry.—Samuel G. Hibbs, M.D., Tampa.

Epidemic Transient Situational Disturbance in an Elementary School

Joel L. Nitzkin, M.D., M.P.H.

ABSTRACT: One morning the Dade County Department of Health was notified of an outbreak due to suspected poison gas at a local elementary school; 34 children had been sent home or to the hospital. The most commonly reported symptoms were headache, dizziness, nausea, chills, abdominal pain and shortness of breath. Prompt investigation revealed no firm evidence of any known communicable, toxic or allergic phenomenon. The stressful circumstances surrounding the outbreak, apparent transmission of illness by sight and sound, female preponderance, correlation between severity of illness and prior impression of neurosis and/or hypochondriasis by school staff implicated an epidemic transient situational disturbance. Both confirmation of diagnosis and cessation of the outbreak were accomplished by public announcement of the diagnosis of "mass hysteria."

Introduction

Epidemic transient situational disturbances are well documented in the medical literature.[1-16] Usually the older and technically inaccurate term "mass hysteria" has been used. Frequently this diagnosis has been considered only after all other possible diagnoses have been ruled out. This in turn has caused difficulty in the management of outbreaks in which the investigation has resulted in continuation of the epidemic.[4,5,7,8,13,16]

The purpose of this report is to present a recent outbreak of "mass hysteria" to demonstrate how prompt recognition and announcement of the diagnosis can terminate an epidemic.

The Epidemic

The index case, an 11-year-old girl in the fifth grade, experienced onset of illness about 9:30 a.m. while standing in rehearsal for a major musical production in the school cafetorium. The group consisted of 169 fourth, fifth and sixth grade children. About 80% were fifth and sixth grade, 50% were female. After 20 to 30 minutes of singing the girl began to experience dizziness and headache and had to lean on the stage behind her for support. A few minutes later, while the teacher was looking the other way, she left the cafetorium and fainted in a clinic across the hall. The teacher didn't see this but most of the child's classmates did.

She was also seen by one of the clerical staff in the principal's office. Smelling salts didn't wake her so the clerk promptly summoned the local fire-rescue service.

By unfortunate coincidence the fire-rescue service arrived at the school as the hallway was filling with children leaving the cafetorium. The uniformed fire-rescue personnel made their way through the children in the hall, into the clinic and reappeared moments later carrying out the index patient unconscious, on a stretcher for all to see.

Other children began to experience onset of illness at that time. The first cases were in children leaving the cafetorium. During the next hour cases began occurring in other parts of the school as word of the outbreak and rumor of a gas leak spread throughout the school. Almost immediately additional fire-rescue units, police units, school and community dignitaries and representatives of almost all major South Florida news media converged on the school.

By the time investigation began eight of the most severely ill children had been taken to a nearby hospital. Six of the eight had been transported by fire-rescue and two were taken by their parents. A telephone call to the hospital revealed that four of the eight were clinically well on arrival, one was hyperventilating and three had complaints of residual nausea, headache and fatigue. Blood counts, blood gasses, electrolytes, blood chemistries and urinalyses were done and all were within normal limits. Of these eight children, one was ill when she arrived at school that morning with an apparent mild viral enteritis, five were known to the office staff as children with severe behavioral problems,

From the Office of Consumer Protection, Dade County Department of Public Health, Miami.

hypochondriasis and/or frequent absenteeism due to illness. The remaining two, including the index case, were considered within normal limits for behavior, illness and absenteeism.

Because of the nausea, headache and reports of an unusual smell in the school, an emergency room physician had informed the children, parents, news media and representatives of fire-rescue that the children must have been exposed to a toxic gas.

At 10:30 a.m. the health department was called to provide nursing assistance for the children affected by the poison gas. The health department epidemiologist (JLN) arrived at the school at 11:15 a.m. By then 34 children had been sent home or to the hospital. The clinical picture varied from child to child. The most commonly reported symptoms were headache, dizziness, nausea, chills, abdominal pain and shortness of breath. Two of the children were noted to have full-blown hyperventilation syndrome.

Of the 34 patients sick enough to be sent home or to the hospital, 27 (79.4%) were in fifth or sixth grade, 11 (32.4%) were male and 23 (67.6%) were female.

An abbreviated environmental survey was immediately conducted in search of a possible source of a toxic gas, toxic fumes or allergens. Bacterial and viral etiologies were ruled out on the basis of the extremely short apparent incubation period and clinical syndromes observed. The unusual smell in the school emanated from an adhesive used under the carpeting in the school library. The faint but distinctive aroma, reminiscient of an organic solvent, had been present in the school since the carpeting was laid two weeks before. The carpeting was ruled out as source of the epidemic because none of the children ill had been exposed to the carpeting that day and those who had been directly exposed did not become ill.

Ventilation in the cafetorium and hallway where most cases occurred was adequate to rule out carbon monoxide narcosis even if there had been an apparent source of carbon monoxide. These impressions were reconfirmed in a much more detailed environmental survey conducted by health department industrial hygiene and sanitation staff the following day.

Minutes after dismissal of the class in question from the cafetorium, another group of children entered through a separate door and spent the next 30 to 40 minutes in musical rehearsal similar to the class before. No one in this second group, including the teacher, was aware of the commotion from the previous class immediately outside the door. No one in this second group experienced illness despite exposure to the room in question.

In the excitement following the first wave of cases and immediately following dismissal of the second class, the cafetorium containing the supposedly poison gas was the room used to collect and house the sick children and serve as staging area for all the school, fire-rescue, news media and public health people to follow. During the several hours from onset to termination of illness, several dozen adults spent time within the room in question. None experienced illness.

At 11:40 a.m. the health department authority on the scene announced to all concerned that there were no clinical, epidemiologic or environmental findings to support the possibility of a gas leak or other toxic fumes as cause of the illness in question. The announcement continued to implicate "mass hysteria with hyperventilation" as cause of the epidemic.

By noon the school was back to normal class and lunchroom scheduling. No more children were sent home ill that day. Absenteeism was within normal limits the next day. Absenteeism remained within normal limits and there was no evidence of even limited recurrence through the last month of school.

A questionnaire survey conducted in the school Thursday morning, May 16, brought the total case count to 73 with 63 (86.3%) in fifth and sixth grade children. Thirty-nine (53.4%) of the patients remained in school without complaint after experiencing mild symptomatology.

Discussion

Review of the relevant English language literature revealed 16 outbreaks similar to the one presented here since the 1920s.[1-16] Search of the literature was complicated by the plethora of terms used to designate epidemic mental illness. Such titles include "A Fainting Epidemic,"[1] "Epidemic of Hysteria,"[3,5,12] "Mass Hysteria,"[4,8,11,15] "Epidemic of Overbreathing,"[9] "Outbreak of Psychosomatic Illness"[16] and others. According to the most current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association[17] the most appropriate diagnostic term would seem to be "Epidemic Transient Situational Disturbance," a term not even alluded to in any references I have reviewed. Even the Index Medicus[18] lists these papers under the term "Hysteria" in the lay, nonpsychiatric meaning of the term.

According to the Diagnostic Manual[17] the term

"Transient Situational Disturbances" is reserved "for more or less transient disorders of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorders and that represent an acute reaction to overwhelming environmental stress."

While not typical of disturbances ordinarily tabulated under this heading, the illness observed in the elementary school more closely approximates this diagnosis than it does the diagnoses of "anxiety neurosis," "hysterical neurosis," "personality disorder," "behavior disorder of childhood and adolescence" or "psychophysiologic disorder" as defined in the Diagnostic Manual. A good case could be made for the establishment of a new diagnostic classification to more precisely describe outbreaks of mental illness such as the one reported in this paper.

With "mass hysteria" as well as other types of epidemic illness, failure to properly identify the illness and its causes can result in substantial morbidity and substantial loss of time and money through the imposition of inappropriate control measures. Continuing investigation by health and medical authorities has perpetuated similar outbreaks and lent credence to fear of the "mystery illness."[3,5,7,8,13,16]

In the present outbreak prompt diagnosis and imposition of control measures (announcement of the diagnosis and return of the school to normal operation) promptly terminated the epidemic. In similar epidemics where this was not done, cases continued to recur over a considerable period of time.[2,5,16] In several of these outbreaks, the diagnosis was strongly suspected early in the outbreak but not acted upon because the investigators apparently believed that such diagnosis could not be announced or acted upon until all other diagnoses had been "completely ruled out."[4,5,7,8,13,16]

The key features which serve to differentiate an epidemic of mass hysteria from one due to a toxic, allergic or microbiologic agent, are as follows:

1. Apparent transmission of illness by sight or sound.[1-16]
2. Recurrences of illness and onset of new cases when original psychological climate is duplicated or reestablished.[2-7,13,16]
3. All or almost all cases in females.[1-16]
4. Adolescent and preadolescent females constitute most or all cases.[1,3,5,6,9,10,11,12,14,16]
5. Illness most frequent and most severe among those children previously suspected to be neurotic and/or hypochondriacal.[1-4,9,10,13]
6. Lack of illness among adults and others sharing same environment as children affected.[1-3,5-7,9,10,14]
7. Evidence of unusual physical or mental stress.[1-16]
8. Prompt cessation of epidemic upon announcement of diagnosis.[3,4,7,9]
9. Clinical laboratory values within normal limits except those altered by hyperventilation.[5,7,9,10,16]

Of these nine criteria the two most specific relate to apparent transmission by sight or sound, and prompt cessation of the epidemic upon announcement of the diagnosis. Practicing physicians and public health authorities should be aware of the possibility of mass hysteria and prepared to take appropriate action when outbreaks similar to the one reported here are brought to their attention.

Extremely careful professional judgment must be exercised in determining the extent of clinical, epidemiological and environmental investigation required before announcement of the diagnosis of mass hysteria can be made. Undue delay in making such announcement may result in substantial potentially preventable morbidity.

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References

1. Olson, W. C.: Account of a Fainting Epidemic in a High School, Psychol. Clinic 18:34-38, 1929.
2. Rawnsley, K. and Lauden, J. B.: Epidemiology of Mental Disorders in a Closed Community, Br. J. Psychiat. 110:830-839, 1964.
3. Schuler, E. A. and Parenton, V. J.: A Recent Epidemic of Hysteria in a Louisiana High School, J. Soc. Psychol. 17:221-235, 1943.
4. Johnson, D. M.: The "Phantom Anesthetist" of Mattoon: A Field Study of Mass Hysteria, J. Abnorm. Psychol. 40:175-187, 1945.
5. Knight, J. A.; Friedman, T. I., and Sulianti, J.: Epidemic Hysteria: A Field Study, Am. J. Pub. Health 55:858-865, 1965.
6. Tan, E. S.: Epidemic Hysteria, Med. J. Malaya 18:72-76, 1963.
7. Kerckhoff, A. C. and Back, K. W.: The June Bug: A Study of Hysterical Contagion, Appleton-Century-Crofts, New York, N.Y. 1968.
8. Jacobs, N.: The Phantom Slasher of Taipei: Mass Hysteria In a Non-Western Society, Soc. Problems 12:318-328, 1965.
9. Moss, P. D. and McEvedy, C. P.: An Epidemic of Overbreathing Among Schoolgirls, Br. Med. J. 2:1295-1300, 1966.
10. McEvedy, C. P.; Griffith, A. and Hall, T.: Two School Epidemics, Br. Med. J. 2:1300-1302, 1966.
11. Pfeiffer, P. H.: Mass Hysteria Masquerading as Food Poisoning, J. Maine M. A. 55:27, 1964.
12. Helvie, C. O.: An Epidemic of Hysteria in a High School, J. Sch. Health 38:505-509, 1968.
13. Goldberg, E. L.: Crowd Hysteria in a Junior High School, J. Sch. Health 43:362-366, 1973.
14. Lyons, H. A. and Potter, P. E.: Communicated Hysteria—An Episode in a Secondary School, J. Ir. Med. Assoc. 63:377-379, 1970.
15. Stahl, S. M. and Lebedun, M.: Mystery Gas: An Analysis of Mass Hysteria, J. Health Soc. Behav. 15:44-50, 1974.
16. Levine, R. J.; Sexton, D. J., Romm. F. J., et al: An Outbreak of Psychosomatic Illness at a Rural Elementary School, Lancet (in press).
17. DSM-II Diagnostic and Statistical Manual of Mental Disorders, Second Edition, Published by American Psychiatric Association, Washington, D.C., 1968.
18. Cumulative Index Medicus, Volume 15, 1974.

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EDITORIAL

Reflections

"An unusual opportunity to serve the physicians of Florida" is the phrase that best encapsulates my feelings after a year as Editor of The Journal.

Among the objectives of all the Editors of The Journal during this past year were: 1) to forge a more powerful link to the Editors of the eight county medical society bulletins, 2) to link the covers of The Journal to the article highlighted in each issue, 3) to publish an informative and varied journal containing items of interest to each member of our Association within the fiscal guidelines established by the Board of Governors, 4) to attract scientific articles of the highest caliber, and 5) to enhance the review process of all articles and documents submitted for publication involving as many physicians and other experts as possible throughout Florida. Such reviewers are listed below with a profound expression of thanks to each of them for their work. The role and mission of The Journal has immeasurably benefited from their efforts. Over 80 percent of the reviewers returned their comments within three weeks after receipt of an article—an unparalleled measure of support.

Being steward of The Journal brings into sharp focus daily the scaffold upon which we presently further the aims of The Journal. To previous Editors, particularly those within the past decade—Drs. Thad Moseley, Franz Stewart, and Clyde Collins—an intense note of appreciation.

Dr. Collins continues to bear many of the daily, and often onerous, chores indigenous to the publication of The Journal. Without such support the continual process of distilling information into a superior publication would be significantly compromised.

The Editor acknowledges with gratitude the top-level support, advice, and encouragement of Dr. Vernon B. Astler in his capacity as our distinguished President, the members of the Board of Governors, and Dr. W. Harold Parham, our Executive Vice-President, who on many occasions has aided the Editor in steering the ship to avoid the shoals, sandbars, and obstacles that encompass such efforts.

The continuing guidance and counsel of Dr. J. Lee Dockery, Chairman of the Council on Scientific Activities, is hereby formally recognized with gratitude.

No Editor could function appropriately without his valued Associate Editors, Dr. Clyde M. Collins and Dr. E. Charlton Prather, who each month spent an evening with the Editor and the staff reviewing literally tens of items that required a decision prior to any action.

Such a process was helped by the on-going effective aid given by the Assistant Editors, Drs. Joseph G. Matthews, William M. Straight, Richard C. Dever, A. Lee Messer, and F. Norman Vickers, and by the Consulting Editors appointed by each FMA-recognized specialty society.

Louise Rader and Edward D. Hagan of the FMA staff in Jacksonville and Linda Kalof of the staff of the Editorial Office in the Department of Pediatrics at the University of Florida form the essential cadre of professional personnel that translate concepts and ideas into integral portions of The Journal, plus performing well the daily innumerable tasks that envelop such an effort.

Dr. Jack MaCris and the Board of Governors have asked me to serve as your Editor for another year. Each of us affiliated with the publication of The Journal look forward to this continuing opportunity.

Sincerely,
THE EDITOR

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It is a very funny thing about life:
if you refuse to accept anything
but the best you very often get it.

W. Somerset Maugham

Alert—Implementation of Florida Nurse Practice Act

The Manpower Committee of the Florida Pediatric Society feels an obligation and urgency in alerting the physicians of the State (as well as its citizenry) regarding certain recent rather sudden developments relative to the implementation of the 1975 Nurse Practice Act. It was felt by the Committee that the results of the recent meeting of the Advisory Committee to the Florida State Board of Medical Licensure and Florida State Board of Nursing Licensure (composed of three physicians and three nurses) could well have a significant impact on the quality of medical care and that nature of medical practice as we now know it for Florida's citizens.

The Nurse Practice Act was signed into law in June, 1975 by Governor Reubin Askew, setting up statutory authority (464.021[2]) for this Advisory Committee and "to define by rule what constitutes specialized and advanced levels of nursing practice as recognized by the nursing profession. The Board shall adopt rules concerning the authority of various categories of nursing practitioners to perform particular acts and certify practitioners in such specialized categories. The Board shall develop such rules as necessary to recognize advanced skills, knowledge, and competence gained through education or professional practice" (464.051[d]).

The first draft, as drawn up by the Nursing Board, listed among other things the categories of the Advanced Registered Nurse Practitioner (ARNP), stating that said practitioner is "prepared to function in a collaborative relationship with other health professionals **without direct supervision** and is responsible and accountable for such practice." Categories include but are not limited to: 1) Family Nurse Practitioner, 2) Pediatric Nurse Practitioner, 3) Adult Nurse Practitioner, 4) Geriatric Nurse Practitioner, 5) College Health Nurse Practitioner, 6) Psychiatric/Mental Health Nurse Practitioner, 7) Anesthetist, 8) Midwife, 9) Clinical Nurse Specialist (e.g., Pediatric, Cardiovascular, Obstetric, Respiratory, Orthopedic), and 10) Occupational Health Nurse.

Functions of Advanced Registered Nurse Practitioners include among others performing comprehensive physical assessments, defining problem areas and outlining remedial plans, making referrals, initiating care during normal pregnancies and deliveries, conducting nurse clinics, community clinics, participating in evaluation of care and modifying as indicated.

The first draft goes on to outline initial and later more permanent requirements for certification, but, in general, include training in **comprehensive physical assessment, making diagnoses,** initiating and modifying selected medications, diet, and therapies, assessing community resources, and initiating and providing emergency treatments.

At the meeting of the Advisory Committee on January 9, 1976, in Tampa, except for two minor revisions this first draft was adopted by the entire Advisory Committee. This in effect released further revisions and participation by the three physicians on this Board and finalized the draft except for changes that might result from decisions made solely by the Florida Board of Nursing after public hearings (which are mandated by statute). Thus the work of the Joint Committee was completed and will probably not be returned to them for further consideration. As a matter of fact, such a meeting was declined by the Board of Nursing only recently.

These public hearings are scheduled for the following locations and times: Jacksonville on May 7 at 7:30 p.m. at the Ramada Inn, Jacksonville Beach; Tampa on May 20 at 7:30 p.m. at the Holiday Inn, Airport, 4500 West Cypress; and in Maimi on May 27 at 7:30 p.m. at the Deauville Hotel, Miami Beach.

It is this Manpower Committee's understanding that following these public hearings, if there were objections or "other input" from those attending these meetings, then the matter would go back to the Florida State Board of Nursing for presumably some revisions to meet the objections. Then probably there would be further public hearings.

The Manpower Committee recognized the Advanced Registered Nurse Practitioner as a reality, but would 1) take exception to the Advanced Registered Nurse Practitioner and would favor the concept of Advanced Registered Nurse Associate; 2) take issue with the term "independent" practitioner concept; 3) oppose abrogation of creative physician input into the planning and curriculum henceforth; and finally 4) implore numerous and effective physician and lay attendance at these public hearings in an effort to create the type of undiluted quality medicine that can be achieved only by ongoing noninsular collaboration and cooperation between physician and nurse.

From the Manpower Committee of the Florida Chapter of American Academy of Pediatrics jointly with the Florida Pediatric Society.

ORGANIZATION

Dr. Astler Retires as President



VERNON B. ASTLER, M.D.

Dr. Astler's Year as Our President

An account of any organization should have portraits of people who greatly affected its history. "An organization," says Emerson, "is the lengthened shadow of one man." Carlyle saw history as being made, not by environment and event, but by "event-making" men and women. This is true of the Florida Medical Association, and it is particularly apropos to our retiring president, Dr. Vernon Astler.

Sunday, April 27, was indeed a significant day for the ten thousand plus members of the Florida Medical Association, for it was on that day that Dr. Astler was installed as it's president. With characteristic dedication, enthusiasm, knowledge, and wisdom, he assumed the many duties and responsibilities in a manner which has made us, as members, extremely proud.

First, there was the initial Board of Governors meeting in which policies and plans were outlined. This was followed by many and seemingly endless number of appearances in Tallahassee on behalf of the members, testifying regarding legislative relief in the professional liability crisis and concerning other legislative matters which affect our daily lives. There followed the decision to enter into litigation against Argonaut Insurance Company, a decision that ultimately was in our favor and saved the members a grand total of thirteen million dollars.

Further along, Vern fought and testified for a 32% increase across the board for Workmen's Compensation rates. Meanwhile, Vern spent countless hours working for the formation of the FMA Insurance Trust and the managing company, PIMCO. He was not too busy to agree to serve as one of the original members of the Board of Trustees of the FMA Trust, and currently is serving in this capacity with distinction.

Later, Vernon found time to testify in Washington before the Subcommittee of the House Ways and Means Committee regarding National Health Insurance, and his knowledge, conviction and eloquence was most impressive to the committee members, especially in his forthright defense of the free enterprise philosophy.

Vern's leadership was again exemplary at the next meeting of the Board of Governors in Barbados at which time important decisions affecting all the members of the FMA were adopted. These included the FMA's role in the next session of the Florida legislature, public relations, continuing medical education, and many others. Another example of Vern's innovative leadership was the success of the special House of Delegates meeting in January at which time more important decisions were made—decisions that are vital to each member's interest.

During the entire year, Vernon has worked diligently and unselfishly for the goal of improving the quality of health care of all the citizens of Florida. At the same time, he has always been the doctor's advocate, forcefully and resolutely. Moreover, throughout the entire year Vern has remained a working doctor, fulfilling his responsibilities to his two partners, to the hospital staff, to the local County Medical Society, to the community in which he lives, but most of all to his patients. Vern has a peculiar and enviable empathy and concern for the sick patients, and many times during the past year we have seen him abandon all other duties when called out by a patient. The patients, nurses, technicians, and colleagues love and respect him for his knowledge, judgment, dexterity, and equanimity.

Furthermore, Vern has remained a devoted husband and father. He has remained well informed regarding many subjects, and has maintained a clear and logical mind in professional and business affairs. He has continued always to be an articulate and gifted orator. As a man, he has been affectionate, appreciative, generous, and humorous. He is unashamed to be a proud patriot and to inform everyone about what is right regarding our great country.

Meanwhile, Vern has not neglected his many hobbies. His golf swing is good enough to give him a 9 handicap, although he hasn't played as often this past year. His newly-acquired tennis game has improved rapidly, but his charming wife, Diane still remains top-seeded, in spite of his super serve. Vern has retained a truly phenomenal memory for almost all sport participants in football, baseball,

basketball, boxing, golf, and racing. One of his secret ambitions is to coach a football or baseball team. He has enjoyed reading, both fiction and nonfiction, watching any sporting event on TV, going to Westerns, hunting, raising dogs, dining at gourmet restaurants, and browsing through art shops. He is an expert on gems, and truly can relax with all types of music.

It has been an outstanding year for the FMA members. Perhaps for Vern this year could be categorized as a tragi-comedy, for we have seen times when this sensitive protagonist has been sad, discouraged, and mildly depressed. However, he retained his good humor, kept all matters in proper perspective, and now we are seeing some of his dreams becoming a reality. It certainly appears as if this story will have a happy ending in May 1976. It has indeed been fortunate that the members of FMA had Dr. Vernon Astler as their president for the past year.

D. L. Van Eldik, M.D.
Lake Worth

I don't know what your destiny will be, but one thing I know; the only ones among you who will be really happy are those who will have sought and found how to serve.

Albert Schweitzer

AMA President Delivers First Jere Annis Lecture



Jere Annis, M.D., Lakeland, Vice Chairman of the AMA Board of Trustees; Wallace Buchanan, M.D., Past Chairman, AMA Inter-Specialty Council; and Max H. Parrott, M.D., Portland, Ore., AMA President.

The First Annual Jere Annis Lecture was presented by AMA President Max H. Parrott, M.D., of Portland, Ore., at the 20th Annual Watson Clinic Seminar in Lakeland on March 13.

A record crowd heard Dr. Parrott speak on "The Winds of Change." The lecture series is named in honor of Jere Annis, M.D., longtime member of the Watson Clinic Medical Staff, Past President of the Florida Medical Association and present Vice Chairman of the AMA Board of Trustees.

The theme of the annual seminar was "New Concepts and Developments in Radiology." In addition to Dr. Parrott, speakers included:

Juan M. Taveras, M.D., Professor and Radiologist-in-Chief, Massachusetts General Hospital, Harvard Medical School, Boston; Ralph J. Alfidi, M.D., Director-Diagnostic Radiology Hospital, Cleveland Clinic, Cleveland, Ohio; E. A. Lyons, M.D., Director-Division of Ultrasound, Health Sciences Center, Winnipeg, Manitoba, Canada; Stuart Gottlieb, M.D., Assistant Professor of Medicine and Radiology; University of Miami School of Medicine, Miami; and Alex A. Bezijan, M.D., Assistant Professor, Obstetrics and Gynecology and Radiology, University of Miami School of Medicine, Miami.

Dr. Burns A. Dobbins Honored by Broward Colleagues



"Dr. Dobbie" and a Little Friend
(Photo courtesy Ft. Lauderdale News)

"I'm one of those nickel-and-dime doctors," Ft. Lauderdale's Dr. Burns A. Dobbins is fond of saying.

Sure enough, when he set up his family practice (it was known as general practice in those days) in a small Tennessee community in the early 1940s, he charged a dollar for an office visit.

"That's what we asked for," he reflected recently. "That's not always what we got."

After a year of dollar office calls, Dr. Dobbie (as he is affectionately called by colleagues) put in a four-year stint as a U.S. Navy Medical Officer during World War II. Upon discharge in 1946, he established a pediatric practice in Ft. Lauderdale, becoming one of that area's first pediatricians.

In the ensuing three decades, hard work and devotion to his profession, assisted by a congenial personality and a quick sense of humor, earned for Dr. Dobbie first a state, then a national reputation.

A highlight of his career came one night last March when he was honored as Broward's "Physician of the Year." Doing the honors was the exclusive Caducean Society, an educationally-oriented group whose membership is restricted to two physicians from each specialty. The citation was for "outstanding service to the community in the field of medicine."

"I am quite flattered," said the man who once was President of the Broward County Medical Association;

—the man who has ably represented Florida doctors for many years in the House of Delegates of the American Medical Association.

—the man who has served with honor and distinction for four years on Medicine's Supreme Court, the Judicial Council of the American Medical Association.

—the man who has served Florida Medicine in many different ways for many years.

—the man whose captivating personality has made him one of Florida's most popular physicians.

—the man who has done so much for children and for Medicine.

Dr. Dobbins and his wife, Estelle, are the parents of two sons. One is an attorney in Ft. Lauderdale, and the other will enter a theological seminary next fall.

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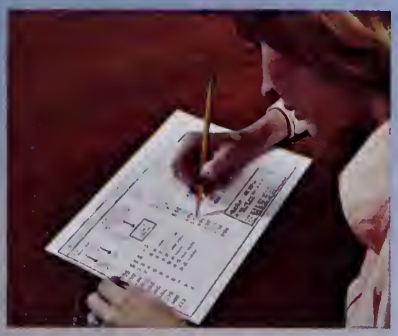
Clinical studies confirm full 12-hour effectiveness.

For years, patients have heard of drugs providing long-lasting relief. But after six or eight hours, they often run out of relief. And it's too soon to take the next dose.

Now, with Novafed A, Dow introduces a prescription capsule with 12-hour effectiveness in relieving allergy and hay fever symptoms. Placebo-controlled clinical studies show that the high level of decongestant in Novafed A provides relief for as long as 12 hours. At the same time, its antihistamine relieves the patient's itchy eyes and runny nose *without* the excessive dryness of anticholinergic agents.

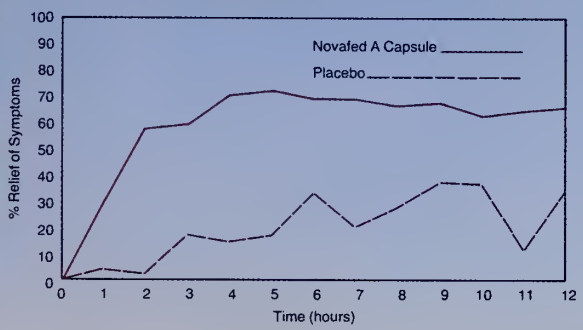
Prompt onset of effect is followed by full 12-hour relief.

(Please refer to the following page for bioavailability studies and prescribing information.)



Patients with severe pollen allergies were tested during hay fever season in a countryside environment and asked to rate severity of five different symptoms on a scale of 1 to 4.

Clinical Study: Degree of Relief from Itchy Eyes and Nose and Throat, Watery Eyes, Runny Nose*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DOW®

Specialists in Cough and Cold Care



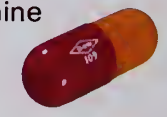
NEW

Novafed® A Capsules

Each capsule contains pseudoephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.



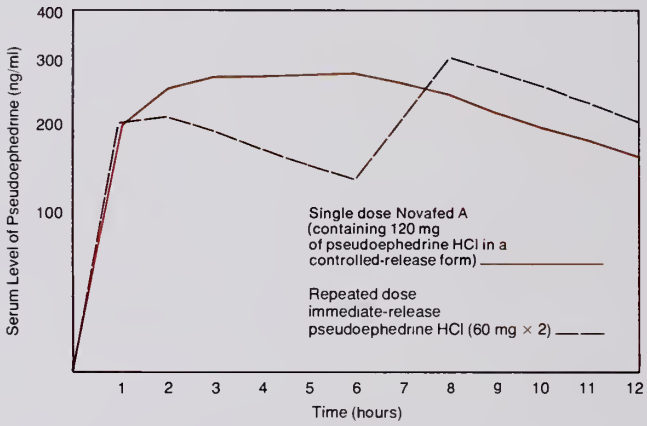
Prompt onset and sustained serum levels over 12 hours

A bioavailability study confirmed that the sustained 12-hour action of Novafed A was comparable to that of immediate-release medication taken at 6-hour intervals.

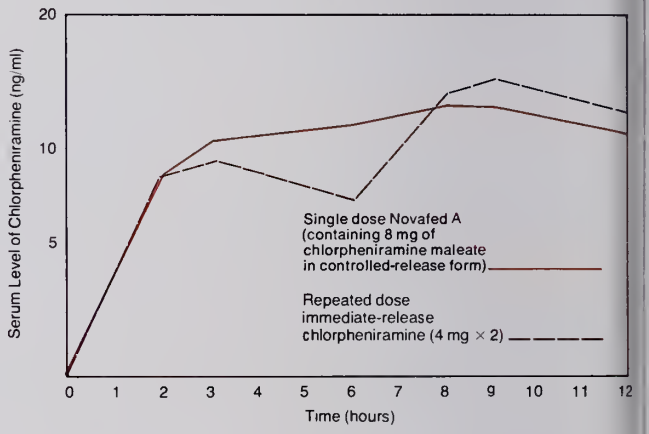
The chart at the left shows the serum levels of pseudoephedrine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 60 mg. pseudoephedrine hydrochloride in an immediate-release form. Serum levels of pseudoephedrine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

The chart at the right shows the serum levels of chlorpheniramine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 4 mg. chlorpheniramine maleate in an immediate-release form. Serum levels of chlorpheniramine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

Comparison of Mean Serum Levels of Pseudoephedrine Following Novafed A and an Immediate-Release Reference Formulation*



Comparison of Mean Serum Levels of Chlorpheniramine Following Novafed A and an Immediate-Release Reference Formulation*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DESCRIPTION: Each NOVAFED A capsule contains 120 mg. of pseudoephedrine hydrochloride and 8 mg. of chlorpheniramine maleate. The specially formulated pellets in each capsule are designed to provide continuous therapeutic effect for about 12 hours. Nearly one-half of the active ingredients is released soon after administration and the remainder is released slowly over the remaining time period.

ACTIONS: NOVAFED A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

INDICATIONS: NOVAFED A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Decongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIONS: Symphathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFED A controlled-release capsules should not be used in children less than 12 years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension or in patients with a history of bronchial asthma.

Do not exceed recommended dosage.

Use in Pregnancy: The safety of pseudoephedrine for use during pregnancy has not been established.

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reaction to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIONS: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Do not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: NOVAFED A is supplied in red and orange colored hard gelatin capsules, monogrammed with the Dow diamond followed by the number 109, in bottles of 100.

DOW®

DOW PHARMACEUTICALS
The Dow Chemical Company
Indianapolis, IN 46268

Specialists in cough and cold care

WELCOME TO THE LAND OF ABUNDANCE...



...WHERE ONLY ONE PRESCHOOLER IN 20 GETS ENOUGH IRON!

That unnerving—and almost incredible—statistic comes from the recently released first Public Health Service survey designed to assess the nutritional status of the *entire U.S. population.**

So when you encounter the apathy, lethargy, irritability and behavior problems that may telegraph such iron deficiency, consider the need for a diet richer in iron. Or, if diet change is impractical, INCREMIN® with Iron Syrup, a remarkably palatable liquid that encourages patient adherence to your instructions.

*First Health and Nutrition Examination Survey, DHEW Pub. No. (HRA) 74-1219-1, National Center for Health Statistics, Rockville, Maryland. (This report indicates that approximately 95% of the children 1-5 years old had iron intakes *below* the standard set by the Food and Nutrition Board of the National Academy of Sciences.)

INCREMIN®

Dietary Supplement

with **IRON** Syrup

Each teaspoonful (5 cc) contains:

Elemental Iron (as Ferric Pyrophosphate)	30 mg
l-Lysine HCl	300 mg
Thiamine HCl (B_1)	10 mg
Pyridoxine HCl (B_6)	5 mg
Vitamin B_{12}	25 mcgm
Sorbitol	3.5 gm
Alcohol	0.75%

DOSAGE: Prevention of iron-deficiency anemia—Children and Adults —1 tsp. (5 cc) daily. Treatment of iron deficiency anemia—Children: 1 tsp. t.i.d.; Adults: 1 tsp. q.i.d.

SUPPLY: Bottles of 4 fl. oz. and 16 fl. oz.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965 Lederle

769-6

Commentary

Large Scale Flu Vaccine Program Planned

During recent weeks the federal government has proposed, with the approval of President Ford, a massive vaccination program to prevent a possible epidemic of influenza next year. This proposal was based on recommendations by the President's Advisory Committee on Immunization, as well as representatives from the Center for Disease Control, the World Health Organization and others. The strain of influenza which the program is aimed at preventing is a newly identified swine virus which represents a major change from viruses which are currently circulating in the human population. The new strain of human influenza virus designated A/New Jersey/76 (H swINI) was first isolated in an outbreak of respiratory disease among recruits in training in Fort Dix, New Jersey.

Influenza swine virus is known to be antigenically stable as compared to other influenza strains which have commonly caused disease in humans.

This same or similar strain of swine virus is felt to be responsible for the pandemic of influenza of 1918. This hypotheses is based on recent epidemiologic data revealing an 80-85% prevalence of swine virus antibody in the greater than 50 year age group. This can be compared to a prevalence of less than 1% in younger age populations.

A fairly constant observation is also that in previous years when new antigenic strains of influenza have appeared in the community (1958, 1968), increased mortality from influenza has occurred. Thus, whether or not this strain demonstrates the same virulence as the 1918 strain, increased mortality can be expected.

The above epidemiologic data in combination with the fact that no evidence of seeding of swine virus has occurred in the community makes this situation rather unique and the call for mass immunization most rational at this time.

The planned mass immunization program was discussed in considerable detail with representatives of all State Health Departments and Medical Associations on Friday, April 2, at CDC in Atlanta, Georgia. The plan, as outlined at the meeting, calls for the immunization of the high risk population with a bivalent vaccine containing A-swine virus and A-Victoria virus beginning in August. Florida's high risk population is larger proportionately than most other states—about 1½ million people. The remainder of the population will be immunized with a monovalent vaccine containing only the A-swine virus beginning in September. Based on available data, the vaccine's efficacy could be as high as 80% in preventing serious disease. Tests are being initiated to determine at which ages the vaccine will be recommended since it is not clearly known whether it will be feasible to immunize preschool age or elementary school age children. The plan proposes to prevent the possibility of a pandemic similar to the 1918 outbreak which was unique with its high mortality, with many of the fatalities occurring among healthy young men and women. Worldwide it is estimated that there were about 20 million deaths with about a half-million deaths in the United States. By comparison, the Asian flu of 1957, caused an estimated 70,000 deaths, primarily among the elderly or individuals with chronic illness.

The plan, as put forth at the conference, proposes to immunize approximately 200 million Americans by December 1976. Such a major immunization program has never been attempted. It would require a massive effort by both public and private sectors of medicine and calls for close cooperation and coordination between the federal government, state health agencies, the private sector, industry, and other health related resources. A combination of mass immunization techniques where appropriate,

and utilization of delivery points already in place such as physicians offices, health department clinics, and community health centers would all be utilized to deliver vaccine. Provision of the federally supplied vaccine to doctor's offices will probably call for some sort of certification procedure to allow physicians to charge for administering the vaccine but not for the vaccine itself.

Further information with regard to organization and implementation of the program will be made available through state and local health departments, as well as State and County Medical Societies as Florida's plan is formulated. We urge everyone's cooperation in this rather formidable undertaking. Much thought and discussion have gone into this recommendation which will cost upwards of $135 million to implement on a national scale. As one editorial in a local Florida newspaper put it, "Obviously, federal officials have no choice but to gamble with our money rather than our lives."

E. Charlton Prather, M.D., M.P.H.
Staff Director, Health Program Office, DHRS
Tallahassee
Kenneth A. Horn, M.D., Pediatrician
Jacksonville
Larry A. Dodd, Immunization Coordinator
Health Program Office, DHRS
Jacksonville

Dr. Prather is an Associate Editor of The Journal of the Florida Medical Association.

WHERE WOULD THE CAMERA HAVE BEEN, WITHOUT A COLLEGE EDUCATION?

Still making Daguerreotypes, probably.

Instead, photography is a billion-dollar business today. Because inquiring minds, trained and honed on college campuses, started looking into chemicals and film and lens.

Life-saving pharmaceuticals. Hunger-fighting new rice and new wheat. Petrochemicals. Radio. Television. The list of billion dollar industries that got their start in college-trained minds is startling.

You don't want the flow of college-bred new ideas, improvements, inventions to stop. Ever. Not if you're a *good* businessman.

So perhaps you'd better take a good hard look at how much your company is giving to higher education. Because inflation has hit colleges and universities even harder than most.

Freedom to experiment is the first casualty of tight budgets.

For the sake of the future, "Give to the college of your choice. Now." Who knows what billion-dollar business of tomorrow is germinating on some college campus today.

CFAE Council for Financial Aid to Education, Inc.
680 Fifth Avenue, New York, N.Y. 10019
A Public Service of This Magazine & The Advertising Council



ONE-SEVENTH OF YOUR EMPLOYEES MAY BE DYING. HELP SAVE THEIR LIVES.

High Blood Pressure is the country's leading contributor to stroke, heart disease and kidney failure. Any of which can kill.

And, one out of every seven of your workers has it. Half have no idea they're walking around with this time bomb inside them.

But you can help. By giving your employees a chance to check their blood pressure. Your own medical or nursing personnel can do the job, simply.

To help you implement this life-saving program, we have a special kit, "Guidelines for High Blood Pressure Control Programs in Business and Industry." Write to: National High Blood Pressure Education Program, 120/80, National Institutes of Health, Room 1012—Landow Bldg., Bethesda, Md. 20014.



HIGH BLOOD PRESSURE. Treat it...and live.

The National High Blood Pressore Education Program, U.S. Department of Health, Education, and Welfare.

A Public Service of this Magazine & The Advertising Council

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

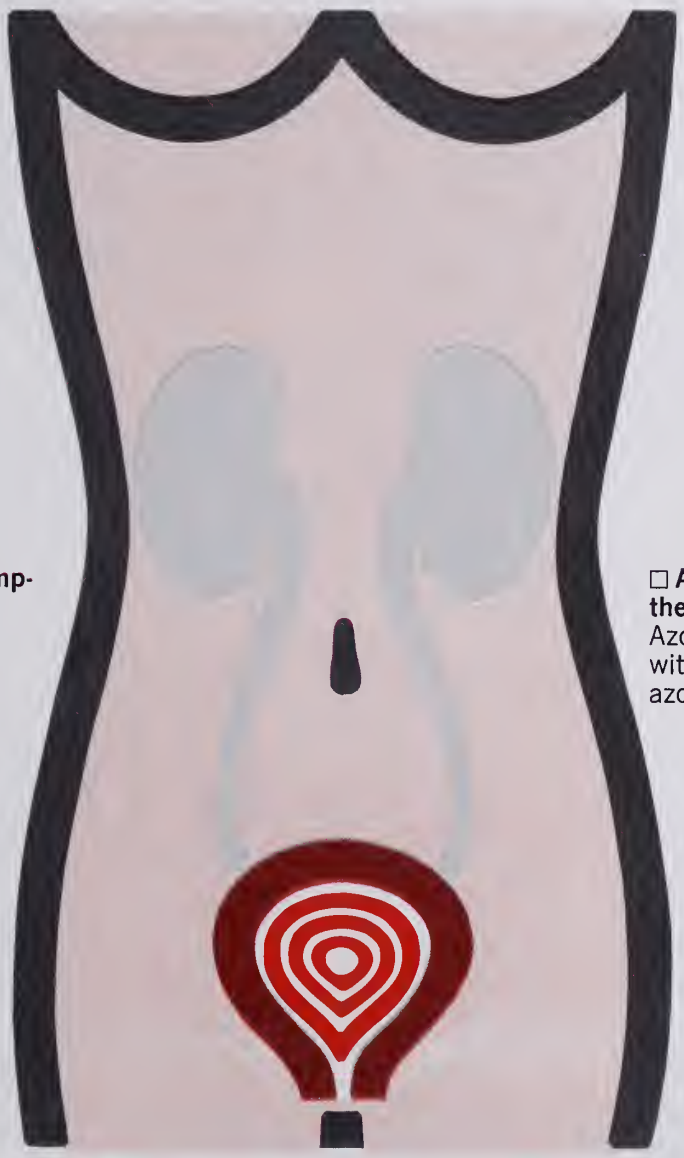
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain for the pathogens



☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

*Warning

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

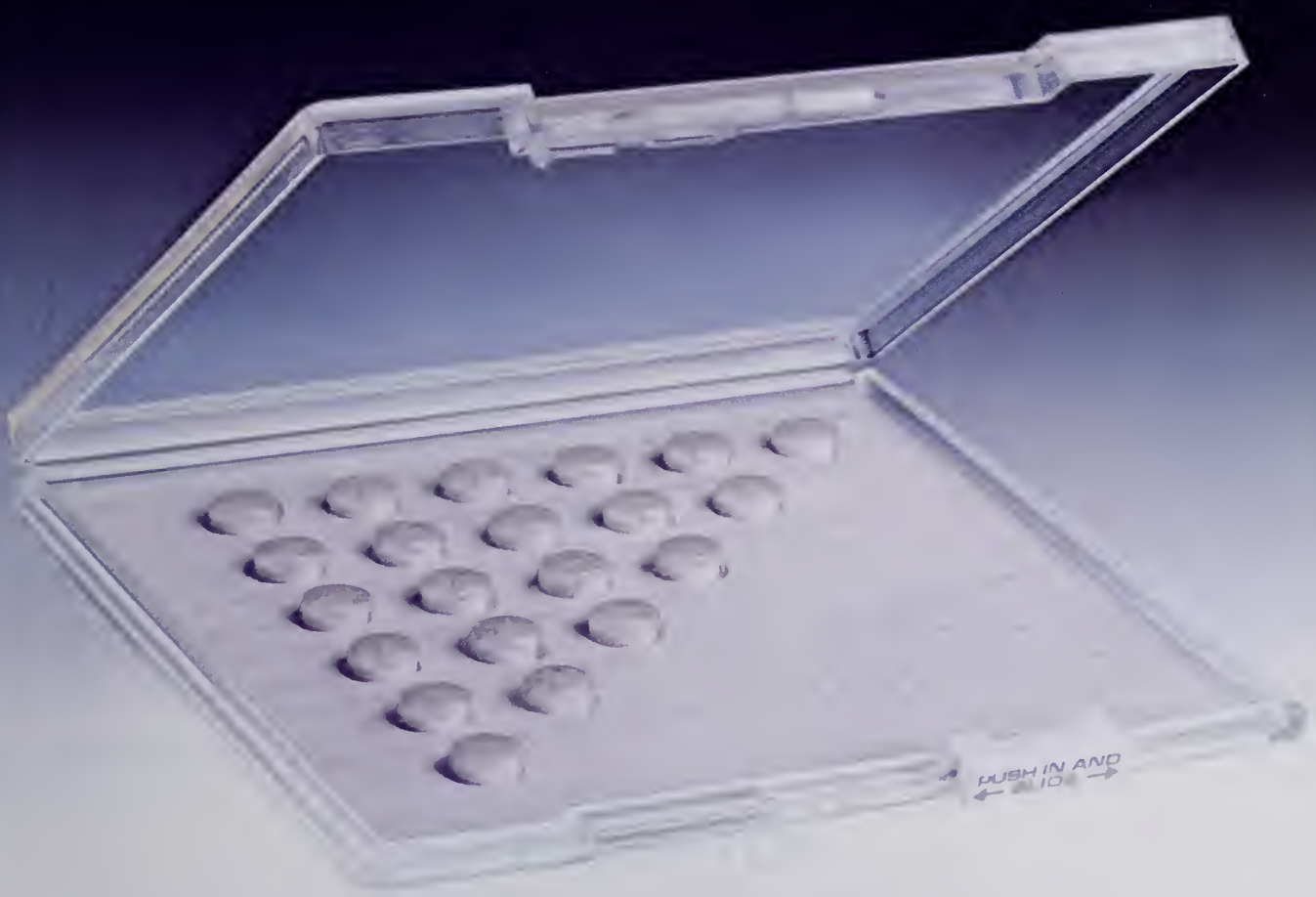
Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

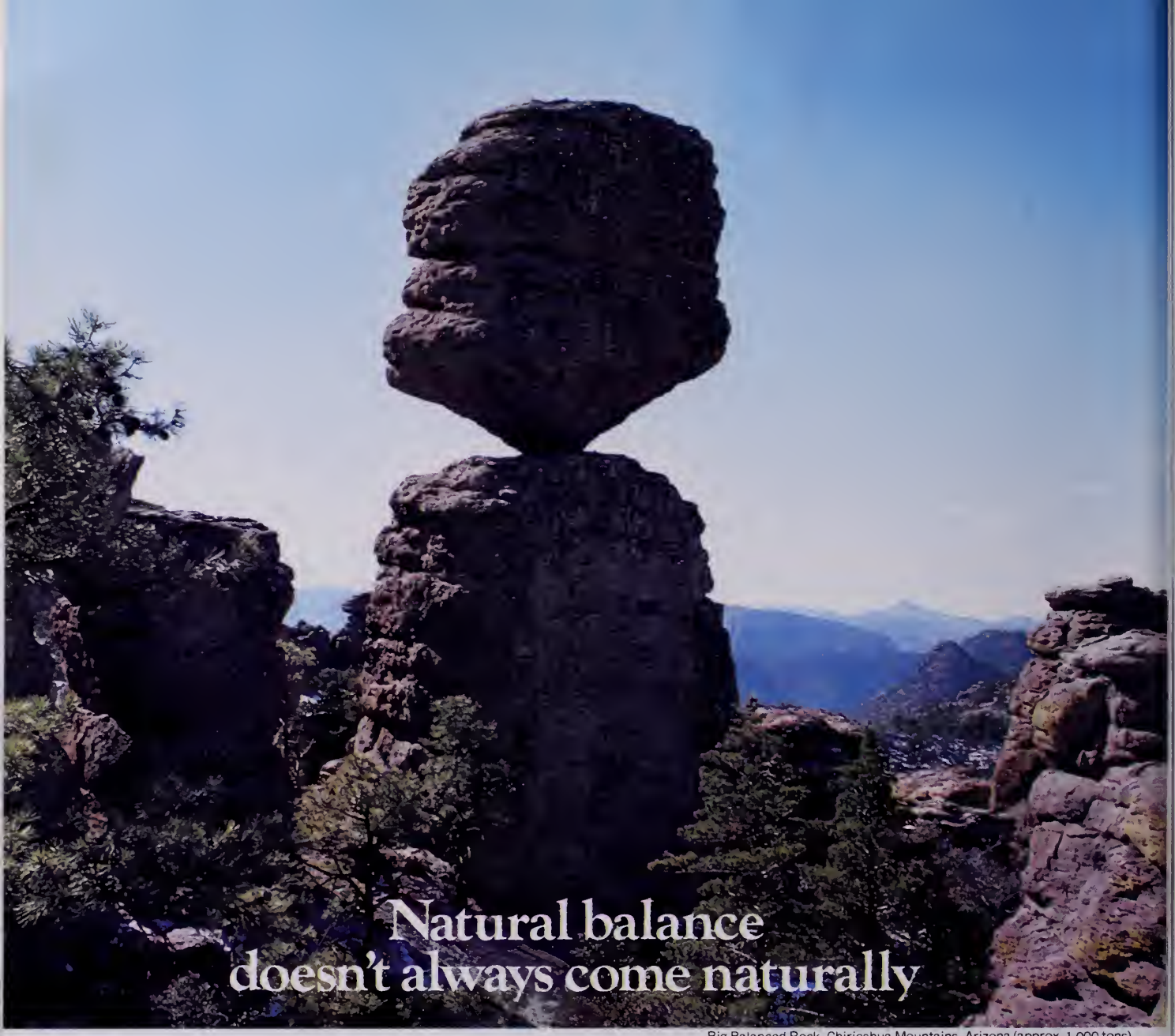
Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



*Trademark



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
□ Can relieve nausea and vomiting often associated with vertigo.*
□ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pre nancy or to women who may become pregnant is contraindicated in view of th teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestatio has produced cleft palate in the offspring. Limited studies using doses of over 100 mg kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palat Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hype sensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patien should be warned of this possibility and cautioned against driving a car or operatir dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in childre have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurr vision have been reported.

More detailed professional information available on request.

ROERIG Pfize
A division of Pfizer Pharmaceutica
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



A New Publication . . . has joined Florida's family of medical journals, bulletins and newsletters.

It's the **"O.P.E.N. Eye,"** and the acronymn is short for "Ophthalmic Physicians Education Network." The four-page newsletter is, according to a legend beneath the flag, "provided by doctors of medicine through the **Florida Society of Ophthalmology** for the protection of the public.

The entire maiden issue is devoted to the alleged improper use of drugs and "dangerous attempts to diagnose and treat eye disease by limited practitioners who are not Doctors of Medicine."

Readers are invited to address communications to 5013 Central Avenue, St. Petersburg, Florida 33710.

Family Practice Board Takes Stand on Hospital Privileges . . . The American Board of Family Practice has re-affirmed its position that its diplomates be accorded the same consideration as other specialists in hospital staff appointments.

Meeting at Marco Island, Fla., the Board stated that certified family physicians should be eligible for full privileges in departments of family practice and for privileges in other clinical departments in accordance with their by-laws and based upon training, experience and demonstrated abilities.

"This tells our family practice residents . . . that we mean business when it comes to hospital privileges," a Board spokesman said. ". . . We will do everything in our power to see that they are not discriminated against at any time, anywhere, either officially or unofficially."

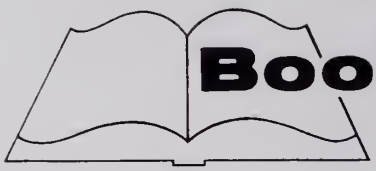
In another action, the Board decided to permit diplomates who fail the recertification examination once to retake it an unlimited number of times provided continuing education requirements are met, legal requirements are satisfied and the examination fee of $150 is paid.

Bibliographies of published material . . . on physicians assistants and handicapped persons have been compiled at the University of Florida.

The physicians assistant bibliography lists articles and books published from 1973 to January 1976. The handicapped persons list is a selected bibliography containing references about and by handicapped people from the 1950s to December 1975.

Bibliographies may be obtained from the Reference Librarian, J. Hillis Miller Health Center Library, Gainesville, Florida.

Dr. Ashley A. Weech, of Gainesville, has been notified that he will receive the Howland Award for 1977 from the American Pediatric Society. This is the top honor awarded a pediatrician from the American Pediatric Society.



Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

JOHN MUIR'S LONGEST WALK by John Earl. 120 Pages. Price $30.00. East Woods Press, Doubleday & Company, Inc., Garden City, N.Y., 1975.

This is a pictorial journal accompanied by excerpts from Muir's original diary of his "walk" from Louisville, Kentucky, to Cedar Key, Florida, in 1867. John Earl, a nature photographer of considerable skill, has compiled a series of photographs—some 9x10—that convey the mystery and beauty that must have moved Muir to his numenistic* enthusiasms. Much of Muir's journey and many of the photographs are placed in Florida, so the book is of special interest not only to Muir aficianados but to lovers of Florida as well.

The photographs include landscape scenes, wildlife, plants and flowers, and carefully avoid depicting the despoilation that has occurred along this route during the past century.

Although Muir has become well known in recent years because of increasing environmental awareness, his walk in the South and enthusiastic feeling for this land is not well known. Muir spent two months hiking, and another three months convalescing from malaria in Cedar Key. The excerpts reflect his love of the Creator and His creation, his skill as a botanist, and his strength as a woodsman. Although only 29 at the time of this journey, Muir had already fine-honed his understanding of man and nature. It is said that he did not have the opportunity to polish this—the earlier of his writings—but it shines quite enough for me. He says on page 116, "The world, we are told, was made especially for man—a presumption not supported by all the facts. A numerous class of men are painfully astonished whenever they find anything living or dead, in all God's universe, which they cannot eat or render in some way what they call useful to themselves. They have precise dogmatic insight of the intentions of the Creator--."

But Muir leaves the ecclesiastical blunders behind and does what more of us should do—goes for a walk. "I only went out for a walk and finally concluded to stay out till sundown, for going out, I found, was really going in."

Herman Schreiber Jr., M.D.
Pensacola

Dr. Schreiber practiced orthopaedics in Pensacola until a year ago when "he went for a walk."

*Numenistic—relating to the presiding divinity or spirit of a place.—Ed.

VECTORCARDIOGRAPHY by Louis Lemberg, M.D. and Agustin Castellanos Jr., M.D. Second Edition. 260 Pages. Price $16.00. New York, Appleton Century-Crofts, 1975.

In this volume the maieutic* method of Socrates proves of great value in a logical, lucid, step-by-step modern presentation of this important topic. The approach is scholarly in the fashion we have come to expect of these authors. The presentation is basic for teaching purposes.

The additional chapters, since the 206-page First Edition of 1969, afford opportunity to present important new information. The chapters entitled "Left Anterior Hemiblock" and "Left Posterior Hemiblock" are timely and thorough. The expansion of data on ischemia and myocardial infarction to three chapters, 10-11.12 in the new edition, adds a good deal to our understanding and knowledge of this most important area.

The new material in the chapter on Wolff-Parkinson-White (WPW) syndrome further expands our insight into the electrophysiology of this still incompletely understood entity.

Chapter 15, "QRS Vector in the Horizontal Plane," is repeated but Chapter 16, "The Normal ST-T Loop in the Horizontal Plane," is welcome inasmuch as it replaces the need for a request for reprints as suggested in the First Edition.

The reproduction of a section of Raphael's classic painting "The School of Athens" is missing from this edition. The scene of Socrates teaching geometry to a young student was a pleasant cultural interlude.

The volume admirably serves its purpose of: (1) Personalized learning; (2) Stimulating the minds of readers and teachers; (3) Introducing an approach for correct diagnosis with a high degree of accuracy; (4) Clearly defining electrophysiologic events in the heart, and (5) Detailing changes produced by various types of heart disease.

This work can be highly recommended as an introduction to Vectorcardiography.

Samuel Epstein, M.D.
Palm Beach

Dr. Epstein is an Internist (Cardiology) in private practice in Palm Beach.

*Maieutic: designating the Socratic method of eliciting memory. From Greek maieutikos-midwife.—Ed.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Physician's Handbook by Marcus A. Krupp, M.D.; Norman J. Sweet, M.D.; Ernest Jawetz, M.D.; Edward G. Biglieri, M.D. and Robert L. Roe, M.D. 18th Ed. 754 Pages. Price $8.00. Lange Medical Publications, Los Altos, Calif., 1976.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.-O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Diet Away Your Stress, Tension, & Anxiety by J. Daniel Palm, Ph.D. 227 Pages. Price $6.95. Garden City, New York, Doubleday & Company, 1976.

Emergency Management of the Critical Patient, Vol. 2, by J. Clifford Findeiss, M.D. 280 Pages. Price $17.95, Stratton Intercontinental Medical Book Corporation, New York, 1975.

The New Way to Live With Diabetes by Brian Boylan and Charles Weller, M.D. 140 Pages. Price $2.50 (paperback). Doubleday & Company, Inc., New York, 1976.

Foreign Travel Immunization Guide by H. H. Neumann, M.D. 32 Pages. Price $2.50. To order: Send check to Box 611, New Haven, Connecticut 06503.

The Woman Alcoholic by Vera Lindbeck. 28 Pages. Price 35¢. New York, Public Affairs Pamphlets, 1975.

Focus on Care of the Elderly by Donald F. Phillips et al. 114 Pages. Price $4.75. Contemporary Publishing, Inc. Wakefield, Massachusetts, 1975.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus,** volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

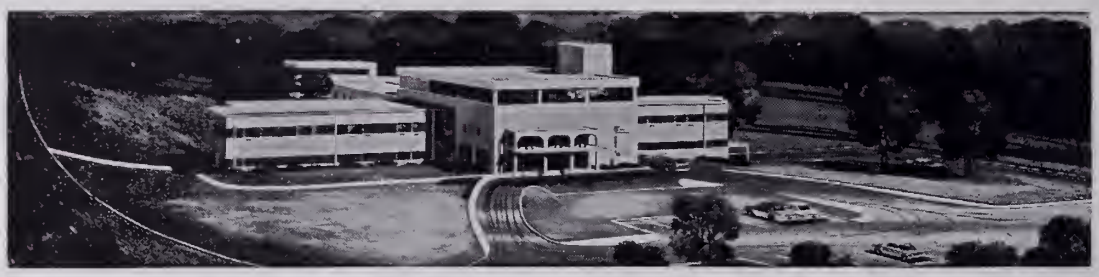
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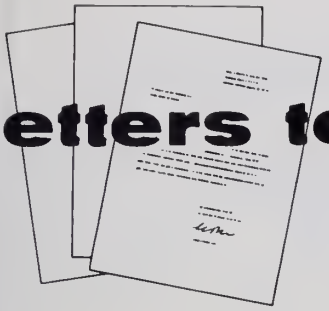
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Letters to the Editor

To the Editor: After reading several issues of the Journal of the Florida Medical Association as organized under your expert care, I have come to the sudden realization that my life to now has been wasted.

I have passed my fortieth birthday, and have few of the honors or experiences that my colleagues have enjoyed. I have never owned a Porsche, incorporated myself, or published anything. A careful review of pre-existing correspondence reveals that not only have my case reports to the New England Journal of Medicine gone unpublished, but I have never contributed an historical note to your fine journal, contributed a footnote to the Pinellas County Medical Association "Mailbag", or any other medical journal. I have not even contributed a paragraph to the Dunedin Elementary School PTA Newsletter. I once attempted to purchase a classified ad in the Clearwater Sun, but this was lost somwhere in the office and never saw print.

In an effort to make up for past sloth, I am going straight to the top in the hopes that you will consider publishing this letter and launching my delayed literary career.

If you are unwilling to publish this contribution, could you at least send me the name and address of a nearby Porsche dealer.

Best wishes in the continued success of your fine work.

Sincerely yours,
Fred O. Smith, M.D.
Dunedin

Dr. Smith is a practicing physician at the Mease Hospital and Clinic, Dunedin.

Editorial Comment

Dear Fred:

Your delayed literary career is hereby launched.
—The Editor

To the Editor: Again this year I am compiling a Biting Insect Summary and would appreciate any case reports of unusual allergic reactions, especially systemic (sneezing, wheezing, urticaria)to bites of insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc.

I would like physicians to supply me with case reports of those patients who have had unusual reactions to such insects. Include in your reports the type of reactions (immediate and delayed symptoms), treatment, the age, sex, and race of the patient, the site of the bite(s), the season of the year, and any other associated allergies.

If skin tests and hyposensitization were instituted, I would like the report of both. Please note that it is the biting (not stinging) insect in which I am interested.

If you have found any insect repellent, local treatment, or insecticides of value, I would also appreciate this.

Please send this information to the following address:

Claude A. Frazier, M.D.
4-C Doctors Park
Asheville, NC 28801

Thank you for your assistance.
Claude A. Frazier, M.D.

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ACCREDITED BY THE J. C. A. H.



Others Are Saying

A Visit to the Doctor
Or
What's it Like to be a Patient?

I called up my doctor to see what's the matter. He said, "come on over." I said, "Do I hafta?" My knees started shaking, my wrists started aching, and then my doctor said to me, "O my, my!"

Ringo Starr

As busy physicians accustomed to dealing with everyday illness, I suspect that we occasionally fail to recognize the anxiety which many patients experience when visiting a doctor's office. Such anxiety, varying from mild nervousness to feelings of sheer terror, usually can be rapidly quelled by the sympathetic words of an understanding physician. Probably there is no better way for a physician to fully appreciate this matter than to suddenly find himself thrust into the role of being a patient. With this in mind, consider what might happen when the typical urbane, erudite physician develops a very special medical problem, namely thrombosed hemorrhoids!

After two or three days of pain in an unmentionable location, a splotch of blood appears and frightens our physician-patient (PP) into calling the friendly neighborhood proctologist. Arrangements are quickly made for a routine office examination. At the appointed time, PP sheepishly waddles into the doctor's waiting room and discovers that half the patients are fidgetly standing while the other half are continually changing their sitting position. Curiosity prevails as PP presses one of the seat cushions noting it to be unusually soft. Shortly after announcing his presence (in the lowest possible audible tone), PP is greeted by the maid who leads him to a small cubicle containing a disproportionately large examining table and walls decorated with beautiful pictures of colon and rectal pathology (in color no less). The maid instructs him to drop his pants and undershorts and lean over the aforementioned table. All of a sudden PP finds himself inverted into a humiliating position which is compounded by the choking produced by a cinched tie and by the realization that items from his shirt pocket are falling to the floor. At this point in time and position, PP meets his doctor, rear to face. While the two exchange greetings, the doctor simultaneously inspects the surface appearance of the involved anatomical part. Concurrent with a few professional utterances concerning the need for a more extensive examination, PP experiences the horrible sensation of a large bore instrument penetrating his very being. Within moments, he complains of dizziness and faintness, but is readily consoled by the maid who pats him on the back and comments, "Take a deep breath, just another six inches to go." At the completion of the examination, PP, looking quite pale, is helped across the hall to a conventional table where he is told to lie down and breathe smelling salts for the next ten minutes. When the doctor returns (this time for a face to face encounter) he brings gifts (an armful of sample medications) and good news ("Everything is all right, but you need an operation."). Finally, as PP starts to leave, his doctor (a happy soul) hands him an apple and advises, "Eat this, it's better than any laxative you'll find."

Daniel B. Nunn, M.D.
Jacksonville

Reprinted from Jacksonville Medicine, March 1976.

Politics is Making Bad Medicine

With the increasing intrusion of politicians, bureaucrats, economists and opportunists into the health care arena, physicians are rapidly warming up to the dangers ahead to the unknowing public, and to their own survival as the best medical system in the world.

A word your Editor read one day was "trans-science." What it means, according to Stephen De Felice, M.D. is that, although we possess proven knowledge about a certain subject, it is impossible —within the scope of present technology—to take specific action regarding that subject and be certain of the outcome. Trans-science, then, can apply to any algorithm or protocol about any given subject.

For example, in Sweden—the so-called cradle of Socialized Medicine—the end result of their medical system, besides bankruptcy and inflation, is a system of a basic charge per complaint, and a 48-hour work week, consisting of four work weeks and two weeks off continually throughout the year. The result of this political and socialistic reform is that there now is a horrible shortage of physicians in Sweden by one third, and queues from one to three years to see an unknown doctor. Incidentally, it is estimated that by 1980, we will have an over-supply of physicians in the United States.

Applied to a different subject, alluded to in a previous editorial in Miami Medicine, is the trans-science of general substitution of drugs. Very seldom does your Editor see the words "bioavailability" vs. "bioequivalence" used. Originally formulated by the "paper doctors" and a Senator from Massachusetts to control the differing costs of the same drug, this piece of legislative junk is costing American lives. Furthermore, it is stifling research by the best drug companies in the world, and saving the patient little, if any, of the cost of medicine. It further takes away the physician's right to prescribe a medicine which he thinks is best for his patient. Generic prescribing is like comparing a piece of coal to a diamond. They are generically equal; but are they equivalent?

Also to be seriously considered, is the fact that the recall of generic drugs is 80 times that of brand name drugs. Ponder the digoxin mishaps. So out of a law evolves a "Frankenstein" result.

Another of the trans-science mix-ups are the recent reports of the rash of pollutants in our water, decaffeinated coffee, cyclamates, cranberries, cherries, lipstick, and poor Charlie the tuna fish.

One would have to drink 80,000,000 cups of decaffeinated coffee a day, drink 6 gallons of pure cyclamates for 20 years, eat a ton of cranberries a year, or eat 350 pounds of cherries a day that contain the Red Dye No. 4 to have a supposedly adverse effect. But why go on? Plain old sugar causes heart attacks and strokes, but have the paper doctors said anything about it?

While still steaming under the collar, let's take another item of many. It seems that the government thinks that the AMA is violating the anti-trust laws by ethically prohibiting advertising, and is taking our organization to court over this issue.

Back in 1847, the AMA was founded in Philadelphia to promote the art and science of medicine and establish a code of ethics to weed out the charlatans. It's been working pretty well. Does anyone know of a physician who won't give you a cost breakdown of his particular field? The government suit will be heard by the time this editorial is in print. If the suit is successful, the results will be interesting. Then we will know who the "bad guys" in medicine are. But how does one convince a past official of the Health Planning Council or the community of this long-standing and idealistic way to protect the public from false and misleading advertising?

Tell me, what is the trans-science limit? Will neon signs be allowed for physicians offering their particular specialties? Should we ask our patients how we should advertise? They will have to pay for it anyway in the long-run. Will there be specials, e.g., free coronaries or ulcers on a week-end? And just what kind of a sign should a gynecologist, urologist, or proctologist exhibit in good taste? There should be no problem if the politicians get into the suit—until the trans-science of physician advertising hits the fan.

Edward W. St. Mary, M.D.
Miami

Reprinted from the Editorial Page, Miami Medicine, March 1976

The Physician and His Manners

In an era considerably removed from our present time, the physician conducted his personal and professional relationships with other physicians with a great deal more graciousness, if we will examine the discourse and associations which take place today between physicians.

On too many occasions, personal letters are written to physicians' offices seeking information for the benefit of a patient, that would help considerably in the evaluation of a patient, avoid repetition of previous studies, and be of a distinct help in caring for a patient. Sometimes these letters are not answered; on too many occasions all the physician receives are xeroxed enclosures of previous medical records, neither abstracted nor put together in any chronological manner. No personal comment is enclosed.

The secretary, and often times other personnel in the office, are used to call other physicians' offices in order to inquire about a patient's records or about information, when a telephone call from one physician to another physician would result in a far better appraisal of the patient and thus lead to more appropriate patient care.

On many occasions physicians ask their secretaries to place calls to other physicians, and the physician, when answering, must await notification of the calling physician, when actually it would have been much better for the physician to place the call himself and speak directly with the physician.

Frequently, consultations are requested without any call ever originating from the physician requesting the consultation; instead, notification is received through some "aide" or "floor assistant" or "clerk." Again, lacking is the courtesy of a personal call from "physician to physician" which would result in far better information being exchanged and ultimately better care for a patient. Personally, as a consultant in medicine, I have for years and years always refused to answer any consultation request, unless the request came to me personally from the doctor involved through a personal telephone call. Perhaps such an attitude upon my part has irritated physicians, but in my opinion there is no substitute for good manners.

If these criticisms of the way medicine is practiced are unjust, perhaps such comments might at least provoke some thought and response, for after all, those of us caring for patients, should "care for each other" and should show evidence of the common courtesies and observance of those long existing relationships, which have made the practice of medicine the "noblest of professions."

J. J. C., Jr.

Reprinted from The Bulletin, Hillsborough County Medical Association, December, 1975.

J. J. C. Jr. is Dr. James J. Crumbley Jr. of Tampa.—The Editor.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

MAY

Sexual Dysfunction and Alternate Life Styles, May 7, Aboard the SS Monarch*

Dental Analgesia and Anesthesia Seminar, May 7-9, Americana Hotel, Miami Beach. For information: Frank Moya, M.D., Mount Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140.

Neurology for Non-Neurologists III, May 13, University of South Florida, Tampa+

The 26th Annual Postgraduate Seminar: Medical-Surgical Dilemmas, May 13-15, Mount Sinai Medical Center, Miami Beach. For information: Miniver S. Reed, CME Coordinator, Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140

Cerebral Circulation and Metabolism, Intracranial Pressure and Anesthesia, May 17, University of Florida, Gainesville**

Anesthesia in the Patient on Chronic Drug Therapy, May 18, University of Florida, Gainesville**

Current Status of Halogenated Anesthetic Drugs, May 20, University of Florida, Gainesville**

▸**Gastrointestinal Endoscopy,** May 20-21, Americana Hotel, Miami Beach. For information: Dr. B. Schuman, 2799 W. Grand Blvd., Detroit 48202

Scientific Bases of Clinical Practice, May 20-23, Innisbrook Resort & Golf Club, Tarpon Springs**

Family Practice Review, May 25-28, Gainesville Hilton, Gainesville**

Cancer Conference: Serum Enzymes in Diagnosis of Malignancy, May 28, St. Joseph's Hospital Auditorium, Tampa. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

1976 Physicians' Seminar on Respiratory Disease, May 28-30, Turtle Inn, Atlantic Beach. For information: A. J. Azcuy, M.D., Box 8127, Jacksonville 32211

Colon Cancer and Lymphadenopathy, May 29, Flagler Hospital, St. Augustine. For information: S.A. Gunn, M.D., 159 Marine St., St. Augustine 32084

A Symposium on Therapeutics, May 29, Howard Johnson's Gulfside, Panama City. For information: M. M. Traxler, M.D., 1109 Harrison Ave., Panama City 32401

Master Approach to Acute Cardiac Care, May 29-31, Contemporary Hotel, Walt Disney World*

Spring Symposia & Cruise in Obstetrics & Gynecology, May 31-June 6*

JUNE

Sixth Annual Radiation Therapy Clinical Research Seminar, June 3-5, Shands Teaching Hospital, Gainesville**

Sexual Dysfunction, June 5, Holiday Inn, Longboat Key. For information: Allen R. Sklerov, M.D., 525 3rd St., E., Bradenton 33505

Family Planning Seminar, June 5, Broward County Health Department, Fort Lauderdale. For information: P.B. Keitlen, M.D., Box 210, Jacksonville 32201

1976 Clinical Conference on Pre-Hospital Emergency Care, June 12-14, Orlando Hyatt House, Kissimmee. For information: ACEP, 1919 Beachway, Suite 5-C, Jacksonville 32207

Florida Suncoast Pediatric Conference, June 14-16, Sheraton Sand-Key, Clearwater*

10th Annual Workshop in Electrocardiography, June 21-26, Sheraton Sand-Key Hotel, Clearwater Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

Florida Academy of Family Physicians Assembly, June 23-27, Marco Island. For information: Marshall D. Brainard, 4057 Carmichael Ave., Jacksonville 32207

Cancer Conference: Annual Report—Cancer Therapy End Results at St. Joseph's Hospital, Auditorium, June 25. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

JULY

Polk County Medical Association Mid-Summer Meeting, July 14-19, St. Thomas, Virgin Islands. For information: T. M. Caswall, M.D., P.O. Box 927, Lakeland 33802

AUGUST

1976 Postgraduate Obstetric Pediatric Seminar, Aug. 10-12, Konover Hotel, Miami Beach. For information: Jorge Deju, M.D., Box 210, Jacksonville 32201

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

▸ National meetings being held in Florida.

SEPTEMBER

Clinical Electrophysiology, Sept. 15-17, Wolfson Auditorium, Mount Sinai Hospital, Miami Beach. For information: CME Coordinator, Mount Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

Twenty Fourth Annual Diabetes Seminar, Sept. 17-19, Jacksonville. For information: Robert Miller, M.D., 1545 San Marco Blvd., Jacksonville 32207.

OCTOBER

First Annual Reunion, University of Miami, Department of Family Medicine, Oct. 3-5, Americana Hotel, Miami Beach*

Topics in Family Medicine 1976, Oct. 6-10, University of Miami School of Medicine, Department of Family Medicine*

17th Workshop in Electrocardiography for Cardiac Nurses & Interested Physicians, Oct. 14-18, Tides Hotel, Redington Beach, St. Petersburg. For Information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

25th Basic Colposcopy Course, Oct. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Charles B. Slack, Inc., 6900 Grove Rd., Thorofare, N.J. 08086

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel, Key Biscayne.*

FSIM/ACP Joint Fall Meeting 1976, Oct. 22-24, Marco Beach Hotel and Villas, Marco Island. For information: Florida Society of Internal Medicine, 515 Lomax St., Jacksonville 32204

1977

JANUARY

9th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-22, Carillon Hotel, Miami Beach. For information: Charles Lynne, M.D., 1200 N.W. 10th Avenue, Miami 33136

FEBRUARY

Symposium on Stroke—Moderns Trends in Cerebrovascular Disease, Feb. 9-12, Diplomat Hotel, Hollywood. For information: Mr. Ronald A. Nelson, Executor Director, Heart Association of Broward County, 440 N. Andrews Ave., Fort Lauderdale 33301

Approved CME Meetings

Neonatal Care — 1974 (Wednesday) 7:30 p.m.-10:00 p.m., Tampa General Hospital, Tampa

Pediatric Grand Rounds (Friday, holidays excluded) 9:15 a.m.-10:00 a.m., University Hospital, Jacksonville

Pediatric Conference (Wednesday) 9:15 a.m.-10:00 a.m., Jacksonville Children's Hospital, Jacksonville

Graduate Level Courses in Family Practice (Weekdays), University of Miami School of Medicine*

Weekly Teaching Conference (Tuesday), Morton E. Plant Hospital, Clearwater

Peer Teaching Conferences (Wednesday), St. Vincent's Hospital, Jacksonville

In-Service Tutorial in Pediatric Cardiology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Neonatology (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Radiology (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer Diagnosis & Treatment (Arranged), University of Miami School of Medicine*

Current Concepts in Cancer In-Hospital Training Program (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Otolaryngology (Arranged), University of Miami School of Medicine*

Grand Rounds in OB-Gyn. (Friday) 8 a.m., Conference Room, Second Floor, Tampa General Hospital, Tampa

Consultant Teaching Seminars, Family Practice (Weekly, Alachua General Hospital, Gainesville

In-Service Training in Family Medicine (Arranged), University of Miami School of Medicine*

In-Service Tutorial in Cardiology (Arranged), University of Miami School of Medicine*

Courses of Instruction in Coronary Care for Practicing Physicians (Arranged), University of Miami School of Medicine*

Practical Aspects of Family Medicine (Arranged), University of Miami School of Medicine*

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Clinical Pharmacology Lecture Series, 8:30 a.m., 4th week of each month, Sept. 1974—May 1975, Memorial Hospital, Hollywood

Tuesday Evening Lecture Series, Department of Anesthesiology, Time: 5-6 p.m. Nov. 19; Dec. 17; Jan. 21; Feb. 11; Mar. 11; Apr. 15; May 13, Jackson Memorial Hospital, Miami

Visiting Professor Schedule, Department of Anesthesiology, University of Miami School of Medicine, Miami* — Nov. 18-20; Dec. 16-18; Jan. 20-22; Feb. 10-12; Mar. 10-12; Apr. 14-16; May 12-14

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Family Practice Conference (Tuesday), Bayfront Medical Center Conference Room. St. Petersburg

Neurology Workshop (Wednesday). A. Vance Morgan Educational Center, South Miami Hospital

Pulmonary Disease Processes (Wednesday), South Miami Hospital, Miami

Medical/Surgical Conference (Thursday), Bayfront Medical Center Auditorium, St. Petersburg

Hematology/Oncology Conference (Every other Thursday), Bayfront Medical Center Auditorium, St. Petersburg

Medical Office Management (Every other Thursday), Halifax Hospital Medical Center, Daytona Beach

Dialogue (Friday), A. Vance Morgan Educational Center, South Miami Hospital

Clinical Pathological Conference (Every 3rd Friday), A. Vance Morgan Educational Center, South Miami Hospital, Miami

Saturday Morning Chest Conference, Physicians' Library, Alachua General Hospital, Gainesville

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PATHOLOGIST, 39, married, board certified in anatomic and clinical pathology, 6 years experience in large community hospital, seeks position of associate or director available July, 1975, national boards, Florida licensed. Write C-716, P.O. Box 2411, Jacksonville, Florida 32203.

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Service ... 378

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Incremin ... 371

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Darvon ... 338
Nalfon ... 380

Mead Johnson
Vasodilan ... 330

Ortho Pharmaceuticals
Vermox ... 326, 327

Pharmaceutical Manufacturers Assn.
Institutional ... 328, 329

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Institutional ... 386

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Valium ... 322, 323
Azo-Gantanol ... 374, 374a

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100th President of the Florida Medical Association

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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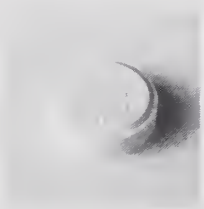
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surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

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Scientific Articles

The Red Tide and Other Phytoplanktonic Thoughts
A. Ashley Weech, M.D. 409
Colonoscopic Surgery
John P. Christie, M.D. 414
Editorial Comment by
Chester Cassel, M.D. 417
The Dizzy Patient—ENG, Yes or No?
Dennis Agliano, M.D. and
Herbert A. Cox, M.S. 418

Case Report

Klinefelter Syndrome Associated With Atrial Septal Defect and Prolapse of the Mitral Valve
David Murray, M.D., et al 421

Special Articles

Multimillion Dollar Adjustment in Workmen's Compensation Fees: A Major FMA Accomplishment
James F. Richards Jr., M.D. 425
Contingency Fees
David J. Lehman, M.D. 427
The National Health Planning and Research Development Act
Luis M. Perez, M.D. 429

Sections

President's Page
Let Freedom Ring
JACK MACRIS, M.D. 397
Books Received 450
Commentary
Medical Director's Role in Skilled Nursing Facility
E. CHARLTON PRATHER, M.D. 439
Summary of the 1974 Florida Maternal Mortality Report 441
Critique by WILLIAM N. SPELLACY, M.D. 442
Liability Insurance Coverage for State Contract Physicians 440
Dean's Page
Current Trends in Graduate Medical Education
CHANDLER A. STETSON, M.D. 406
Deaths 398
Editorial
On the Insanity Defense
ARTURO G. GONZALEZ, M.D. 437
Editorial Comment by
PHILIP B. PHILLIPS, M.D. 437
Legislative News
Consumerism, JOHN C. KRUSE, M.D. 403
Letters to the Editor 445
Medical News Around the State 448
Organization
Jack Achilles MaCris
JOHN E. OREBAUGH, M.D. 433
Others Are Saying
The Waiting Game
RICHARD T. DONELAN, M.D. 451

Information

Classified Advertising 455
FMA Officers and Council Chairmen 458
Information for Authors 450
Index to Advertisers 458
Meetings 452

JUNE COVER — Jack A. MaCris, M.D., of St. Petersburg, 100th President of the Florida Medical Association.



President's Page

Let Freedom Ring

The Bicentennial year of the founding of our country seems an appropriate time to reflect upon the state of our profession. The air is filled with words pertaining to freedom, the right to life, liberty, and the pursuit of happiness, and the dignity of the individual. The virtues of a free society are extolled daily. It is ironic, indeed, to a physician that at such a time his profession's freedom is threatened as never before.

Freedom is essential to the practice of our profession if we are to achieve our best results on behalf of our patients, and it is toward this goal that we constantly strive. The privacy of the doctor-patient relationship is a proven entity in achieving the best medical results. This relationship has been curiously expanded to include the third-party payor, the Government, the Food and Drug Administration, and the news media, to name a few. Consider, for example, the patient's confidence in his doctor when Medicare sends him a notice that his doctor's fee is "more than the allowable charge," or think about the questions that arise in the mind of a patient who has undergone a radical mastectomy, reading the newspaper article proclaiming that the removal of the breast lump alone is just as satisfactory in eradicating the cancer.

Cookbook medicine without consideration of the individual patient has not measured up to the standards of success of individual care. Our patients are not standardized measures of flour, eggs, and milk, which we can baste with penicillin, place in the treatment oven for 6-9 days, and have each come out a fluffy, perfect hot-cross bun. Each has his own imperfect cardiovascular system, immune response mechanism, metabolic reactions, and psychological overlay. Each demands his own special recipe for treatment, as any practicing physician knows.

Generic drugs based on cost, not proven efficacy, is another nightmare. The differences in aspirins are surprising, but not as alarming as the differences which occur in some of the other drugs, such as heparin. To force a physician to prescribe specific products is an invasion of his freedom, to say the very least.

What then are we to do? If we consider our freedom to practice as individuals, and treat our patients as individuals, as being essential in doing our best job for our patients, then we must resist these encroachments.

It would be easier to be sympathetic toward a radical change in our present system of treating people if the proposed systems had demonstrated some degree of success superior to ours. All are failing, both economically and in the delivery of health care. The increased costs, the long waiting list for elective surgical procedures, the exodus of physicians from these systems, the decrease in building new hospitals, the decrease in research, are all glaring examples of failure. Therefore, to scrap our present system for one more expensive, less efficient, and less productive, seems a strange way indeed to solve the problem.

If we sincerely believe our system here to be the best, we are obligated as individuals, and collectively, to make every effort possible to improve and preserve it. We will be fighting for the very existence of our profession as we know it today; to break and run is a betrayal of ourselves, our profession, and our patients.

Let Freedom Ring!

Jack A. Wallis, M.D.

DEATHS

Conkling, Frederick E., Miami; born 1927; Harvard Medical School, 1943; member AMA; died January 21, 1976.

Ferguson, James H., Miami; born 1911; University of Pennsylvania, 1939; member AMA; died January 22, 1976.

Gouaux, James L., St. Petersburg Beach; born 1908; Tulane University, 1932; member AMA; died January 26, 1976.

Holmes, James W., Miami; born 1922; Tulane University, 1946; member AMA; died January 26, 1976.

Kaye, Harry D. L., Coral Gables; born 1918; Harvard Medical School, 1943; member of AMA, died January 23, 1976.

Knight, Jimmie H., Tallahassee; born 1936; University of Miami, 1961; member AMA; died January 15, 1976.

Leone, Frank, Venice; born 1904; Long Island Medical School, 1932; member AMA; died February 20, 1976.

Ombres, S. Richard, West Palm Beach; born 1908; University of Pennsylvania, 1936; member AMA; died December 21, 1975.

Pate, Julien Carey Jr., Tampa; born 1917; Emory University, 1941; member AMA; died January 19, 1976.

Pate, Julien Carey Sr., Tampa; born 1890; Atlanta P & S, 1912; member AMA; died October 26, 1975.

Perez, Guillermo J. Gainesville; born 1935; University of Paris, 1961; member AMA; died December 13, 1975.

Rorebeck, Curtis G., Tampa; born 1918; Emory University, 1943; member AMA; died February 18, 1976.

Womble, William L., DeLand; born 1927; George Washington Medical School, 1955; member AMA; died March 8, 1976.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH * (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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Please see prescribing information on facing page. NSN 6505-00-148-6967

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(pyrantel pamoate) equivalent to 50mg pyrantel/ml



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

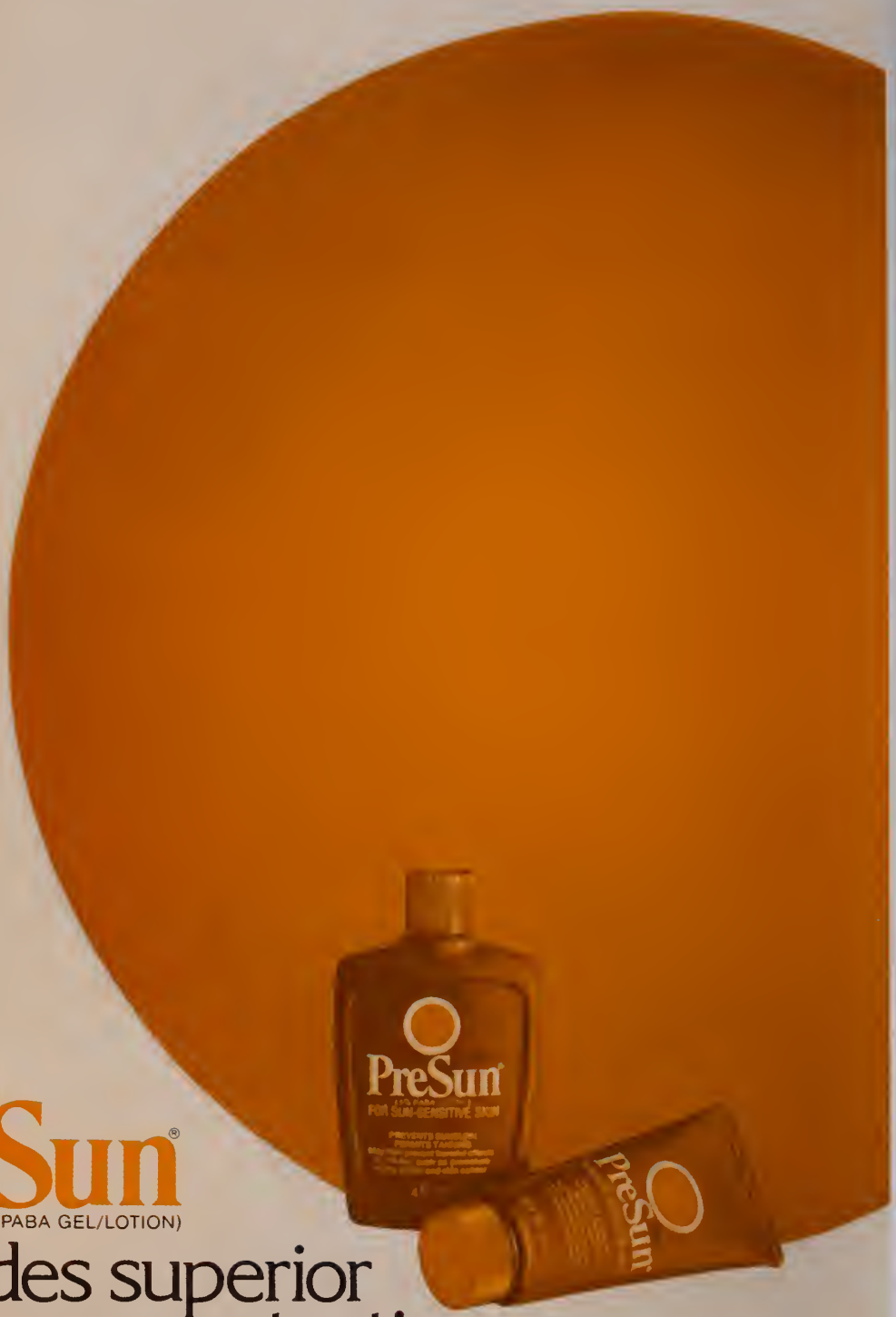
11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005



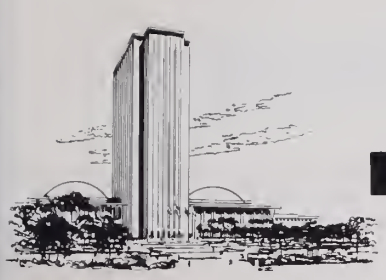
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LEGISLATIVE NEWS

Consumerism

Rather than deal with specific bills in this month's column, since you will read this after the legislature has adjourned, this article will be devoted to the problem of consumerism as it relates to medical practice.

There is a group of legislators, led by Senator Jack Gordon (D), Miami Beach, and personified by Rep. Karen Coolman (D), Ft. Lauderdale, who feel that the profession ought to be licensed, disciplined and controlled by the public. This feeling translates into an absolutely consistent appearance, on any bill relating to health, of language mandating "consumers" on organizations such as the State Board of Medical Examiners, the Blue Shield Board, the Community Health Education Council, etc. This group was successful in passing the HRS re-organization last year which virtually excluded physicians from any policy-making responsibility. "Health care is too important to be left to the doctors." Their long range plan is to tie the doctors to the hospital and then deliver the whole package into the hands of the state regulators, converting health care into a regulated public utility. This pattern emerged very clearly this session and it is guaranteed to come up again.

This push by the liberal bloc in the legislature is the greatest threat to the independence of the medical profession imaginable and the long range threat outweighs even the crisis of malpractice insurance. Florida practitioners should support candidates for office who will aid us in this crucial area.

Perhaps our greatest weakness is that we have tended to be separated from the main stream of community leadership. Public opinion polls show that we have a great deal of respect and support from blue collar people but, in ascending the socio-economic ladder, our respect and support declines. Why?

The struggle to get into, through, and out of medical school and residency, set up a practice, take care of our patients, raise a family and fix leaking faucets, diminishes the time available for civic activities. Few of us are seen on the Board of Directors of Rotary, Kiwanis, Boy Scout and United Fund. The degree of financial support by physicians, compared to other leadership groups, for United Fund, is a repetitive source of criticism. This costs us support from the group who are in positions of leadership and, as a consequence, weakens our positions in the legislature.

The solution to this problem is for each of us to re-examine our time priorities and our position in the community. We owe a deep debt of gratitude to the small group of physicians who have contributed so much to community wide leadership not medically related. I would encourage more of you to get involved. This will not produce immediate results but will give us strength to withstand the liberal attacks on us that will continue for the indefinite future.

JOHN C. KRUSE, M.D., Chairman
FMA Committee on State Legislation
Jacksonville

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DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival.
An insignificant amount of mebendazole is absorbed from the gastrointestinal tract. Most of this is excreted in the urine within three days either as metabolites or unchanged drug.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.
Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.
PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults.
For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.
For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.
If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

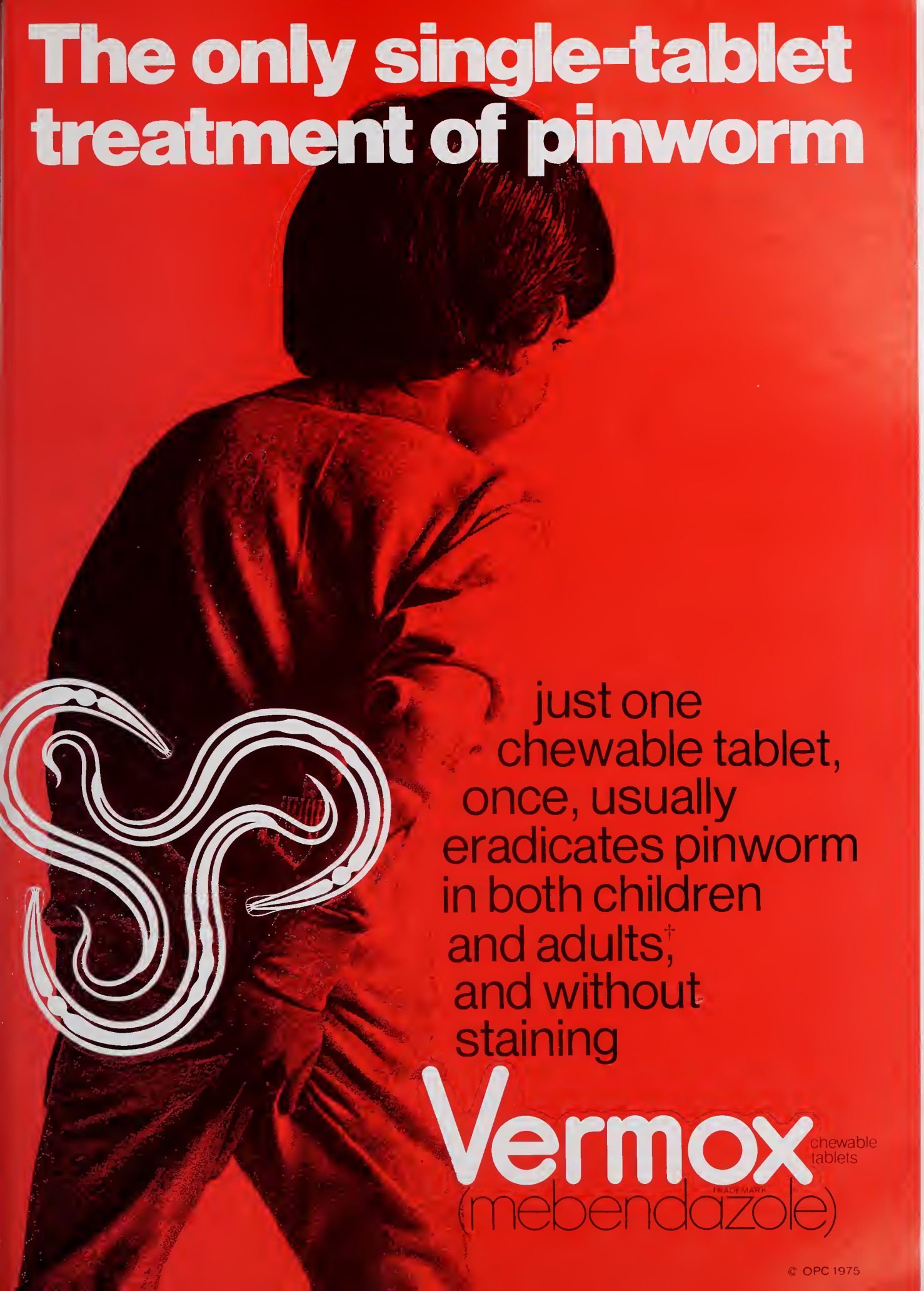
HOW SUPPLIED VERMOX is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
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Dean's Page

Current Trends in Graduate Medical Education

Chandler A. Stetson, M.D.

Data recently released by Dr. John Graettinger of the National Intern and Resident Matching Program (NIRMP) contain some surprises and should be of interest to all of us. This spring, for the second year in a row, there were fewer openings in residency programs than there were applicants. As a result, the number of applicants who went "unmatched" was far higher than it has ever been. In 1970, a total of 9,006 applicants competed for 15,567 places in the matching plan; in 1976, there were 19,796 applicants for 16,112 places. In 1976, 4,513 applicants went unmatched, while in 1970 only 274 applicants failed to match.

The huge increase in the number of applicants over the past six years is due in part to the large number of foreign medical graduates (5,953 in 1976 compared to 470 in 1970) and in part to the increase in the number of graduates from U.S. medical schools (13,843 in 1976 versus 8,536 in 1970). The increase in applicant numbers has occurred largely since 1973, and during that time the number of openings available through NIRMP has fallen from 18,728 to 16,112, largely as a result of the phasing out of free-standing internships.

An analysis of the data reveals that 65% of those applicants who matched successfully were entering "primary care" programs (General and Family Practice, Internal Medicine, Obstetrics and Gynecology and Pediatrics) while another 10% entered programs classified as "Rotating/Flexible." Most of the applicants who failed to match were foreign medical school graduates, but 952 U.S. medical school graduates were unsuccessful. Of those, 83% were seeking primary care residencies.

While the number of openings in primary care programs has been steadily increasing (7,405 in 1974, 8,519 in 1975, 9,060 in 1976), the increase has not kept pace with the increased number of applicants seeking primary care training. In internal medicine, particularly, there appears to be a continuing sizeable disparity. The data indicate that the "specialty maldistribution" problem, however, seems to be correcting itself without benefit of federal legislation or other external controls. That is, more and more graduating students are seeking primary care residencies and more and more openings are being provided for them. Hopefully, the remaining problems can be solved by independent decisions and adjustments by hospitals and students rather than by any sort of national planning and legislation. In the meantime, we will probably go through a period during which we will see a repetition of this year's pattern, with a sizeable number of U.S. medical graduates going unmatched.

Dr. Stetson, University of Florida College of Medicine, Gainesville 32601.

Dr. Stetson is Dean and Vice President for Health Affairs, University of Florida College of Medicine, Gainesville.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE
THIRD ANNUAL REVIEW COURSE
"Fundamental and Clinical Aspects of Internal Medicine"

KEY BISCAYNE HOTEL OCTOBER 10-23, 1976 **KEY BISCAYNE, (MIAMI) FLORIDA**

Directors: William J. Harrington, M.D., Eric Reiss, M.D., and Neal S. Bricker, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for internists who are preparing for certifying examinations. It is intended to provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Each subspecialty will be reviewed as described under "Schedule." Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed texts and references will be provided to all registrants, and audio-visual teaching aids will be available for self-instruction and reinforcement.

SCHEDULE

WEEK I—October 11-16, 1976

October	11	Pulmonary Diseases
"	12	Nephrology
"	13	Hypertension & Acid Base Disorders
"	14	Infectious Diseases & Immunology
"	15	Hematology
"	16	Oncology & Genetics

WEEK II—October 18-23, 1976

October	18	Rheumatology
"	19	Cardiology
"	20	Neurology & Psychiatry
"	21	Endocrinology & Metabolism
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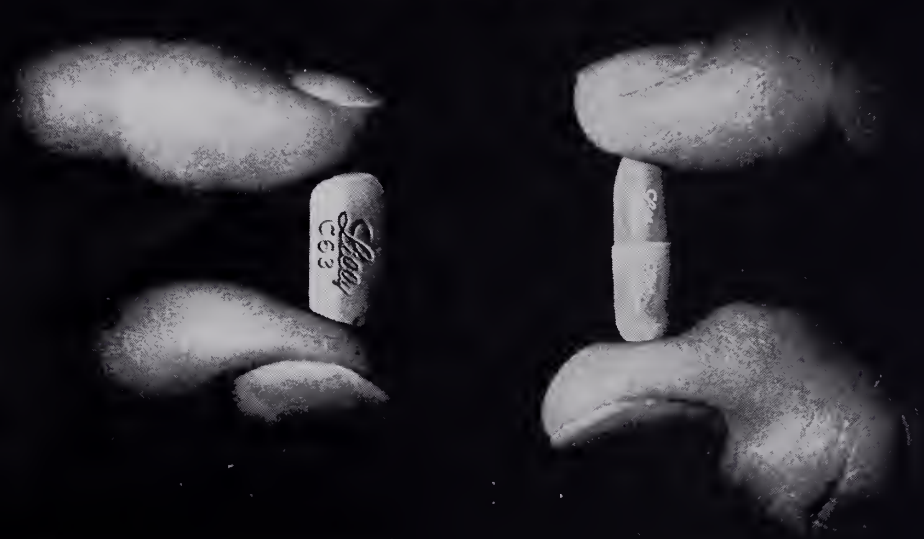
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JUNE, 1976 • VOLUME 63 • NUMBER 6

The Red Tide and Other Phytoplanktonic Thoughts

A. Ashley Weech, M.D.

The text for this essay is found in the second book of the Holy Bible, Exodus 7:20-21, "And all the waters that were in the river were turned into blood, and the fish that were in the river died; and the river stank. And all the Egyptians digged round about the river for water to drink; for they could not drink of the water of the river."

It seems appropriate to begin a dissertation on the Red Tide with what I take to be the earliest recorded reference and, being in the Bible, unquestionably authentic.

Why should I be interested in the Red Tide? The reasons are three in number and I shall enumerate.

Reason number one: Since boyhood I have been a disciple of Izaak Walton. I like to go fishing! I have fished in the Atlantic, in the Pacific, and even in the Indian Ocean. I have fished in waters both north and south of the equator. I have fished in streams, rivers and lakes as well as in the salt water of the sea. On one occasion I tried my luck—it was good—in Great Bear Lake above the Arctic Circle. I have fished with bait (shedder crab, bloodworms, squid, shrimp, night crawlers, wasp grubs, grasshoppers, etc.) as well as with artificial lures (dry flies, wet flies, spoons, popper plugs, darter plugs, and since moving to Florida, with plastic worms). With so much piscatorial experience, with so much fun derived from rod, reel and creel, it is foreordained that I should resent—perhaps I should say, fear—the Red Tide. It kills fish! Of passing interest is the fact that it also poisons human beings. But, more about this later.

From the Department of Pediatrics at the University of Florida College of Medicine, Gainesville. Dr. Weech is Professor of Pediatrics.

Reason number two: The Red Tide is a mischief-maker in waters of the State of Florida and Florida is now my home.

Reason number three: When I moved to Florida in January 1973, I was almost completely ignorant of the nature of the Red Tide. It has been refreshing to brush away some of the cobwebs of ignorance and to share what has been learned with medical students at the University of Florida and, on this occasion, with you.

What Is Red Tide?

What, then, is the Red Tide? It is a discoloration of coastal sea water—sometimes extending into rivers—caused by enormous numbers of tiny unicellular organisms belonging to the order of dinoflagellates. Individually each organism is so small that a thousand of them placed end to end would scarcely reach an inch. There are a number of types. No one type has exclusive rights to the coastal area where it predominates. Some coastal shores seem favorable; others are not. A favorable area will in time note the occurrence of more than one type. This is important because the different types have varying toxic properties and a favorable area harboring a relatively benign type must always be regarded as susceptible to more malignant invasion. Nevertheless, experience has shown that in the United States there are three major types. **Gymnodinium breve** predominates in outbreaks off the west and north Gulf coasts of Florida and occasionally drifts through the Keys to involve the Atlantic coast south from Palm

Beach. **Gonyaulax tamarensis** occurs along the northeast Atlantic coast (Nova Scotia, New Brunswick and in New England from Maine through Massachusetts). **Gonyaulax catenella** is found along the northwest Pacific coast (Washington and Oregon). The Gonyaulax varieties are encased in a hard shell of siliceous material and for this reason can be classed as diatoms. Gymnodinium, as the name implies, is an unarmored or "naked" dinoflagellate.

Small numbers of these protozoa are always present in the waters of the sea. When conditions are adverse they may ensure survival by passing into a resting-type of spore. But, where wind, tide, current, temperature, light, salinity and food are just right, they are capable of multiplying in such enormous numbers as to discolor the water and give rise to a Red Tide. Such an explosion in population density is technically referred to as a "bloom." During the bloom of the winter of 1967-1968 in the Ft. Myers-Marco area **G. breve** counts as high as 10 million per liter were recorded and in 1959 offshore waters near Sanibel Island yielded counts greater than 16 million per liter. At the start of a bloom the Red Tide first appears as patches of colored water. As the patches coalesce water color changes from light green to deep amber and then a reddish tinge. The water becomes more and more slimy until "when taken up in the hand, it runs from the fingers in strings like thin syrup."

The first illustration (Fig. 1) shows a greatly enlarged **G. breve.** I call attention first to the apical process or dome-like hump and the indentation at the base of the hump. These features are unique and can be used to identify the species. Note also the cingulum from which a flagellum emerges. The flagellum aids the cell in propulsion. In motion **G. breve** has been said to resemble a falling leaf as it rolls over and over and moves ahead at a rate of about one meter per hour. Finally, take note of the chloroplasts which suggest that the cell belongs to the vegetable kingdom. Activity of the chloroplasts makes the cell photosynthetic. It is attracted by light and therefore concentrates near the surface during daytime hours. Photosynthesis converts light energy, carbon dioxide and water into chemical energy and its own organic food. In the process oxygen is liber-

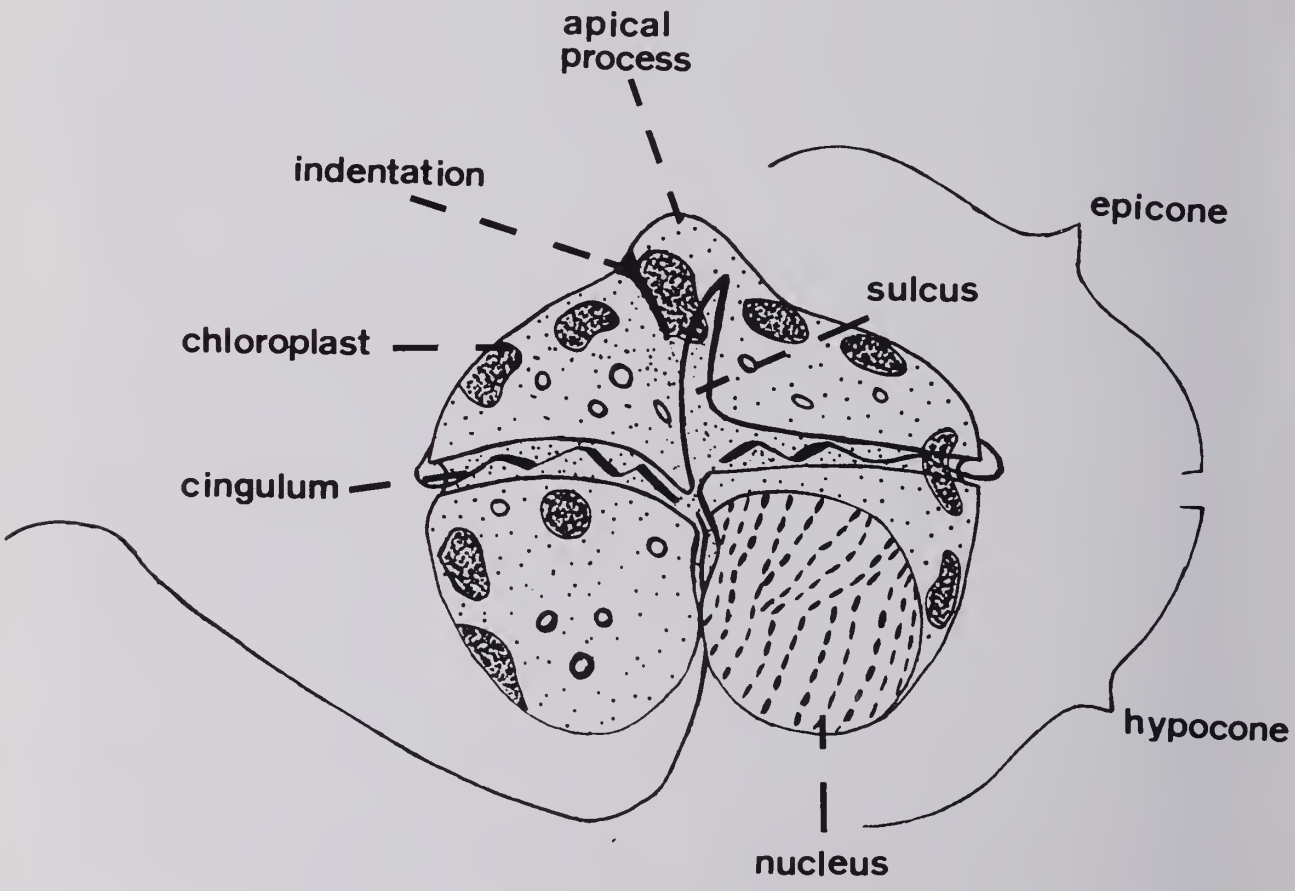


Fig. 1.—Gymnodinium breve. Ventral view. (From Music, Howell, and Brumback, reference 2.)

ated and nutrients are generated that, when eaten, contribute to the survival of animals. But, take note! At night photosynthesis ceases and the cell consumes oxygen. In a sense then this dinoflagellate is a plant by day and an animal at night.

Fish Kills

All dinoflagellates responsible for Red Tides and fish kills produce toxins, chiefly neurotoxins. These toxins vary greatly in potency or degree of toxicity. **Gonyaulax catenella,** the variety that blooms on the north Pacific coast produces a toxin said to be 100,000 times more potent than cocaine. **G. breve** is considerably less toxic. We shall return to its effects on animals and people in a moment.

For the time being let us note that the killing effect is largely confined to vertebrate fish, that is, fish with a well-developed central and peripheral nervous system (Fig. 2). A notable exception is the horseshoe crab **(Limulus polyphemus).** Not all fish are equally affected by the presence of **G. breve.** Bottom feeders like eels and catfish are more susceptible than those living at higher levels. Possibly toxicity is enhanced by anoxia when at night the dinoflagellates sink to the bottom and, in addition to releasing toxin, also consume oxygen. The problem of disposing of dead fish and stench can be of paramount importance. During the summer of 1971 the Red Tide invaded Tampa Bay. In this area fish floating on the surface were prevented from entering residential canals and bayous by oil booms extending across canal mouths. Cleanup crews had to remove the carcasses for disposal on land. St. Petersburg city officials estimated that 2,367 tons of fish were removed at a cost of $156,000. The total economic impact of such piscatorial carnage is difficult to know. Reports of Red Tide ravages appearing in the newspapers of the country discourage the potential Florida visitor who either remains at home or goes elsewhere for his vacation. During the winter bloom of 1953-1954 one authority estimated that the loss to Clearwater, Florida amounted to 3.8 million dollars.

What happens to those fish which encounter the Red Tide but have the stamina to stay alive? The report I bring to you and to all disciples of Izaak Walton is good. There is no evidence that they retain toxin in their flesh. If the fish that takes your lure puts up a good scrap before being coaxed into the net, you may eat without fear and, if it is prepared with fastidious skill, you will experience the pleasure of an epicure.

Effect Upon Humans

What has been said of vertebrate fish does not apply to filter-feeding bivalves, namely, mussels, clams, and oysters. Exposed to dinoflagellates these

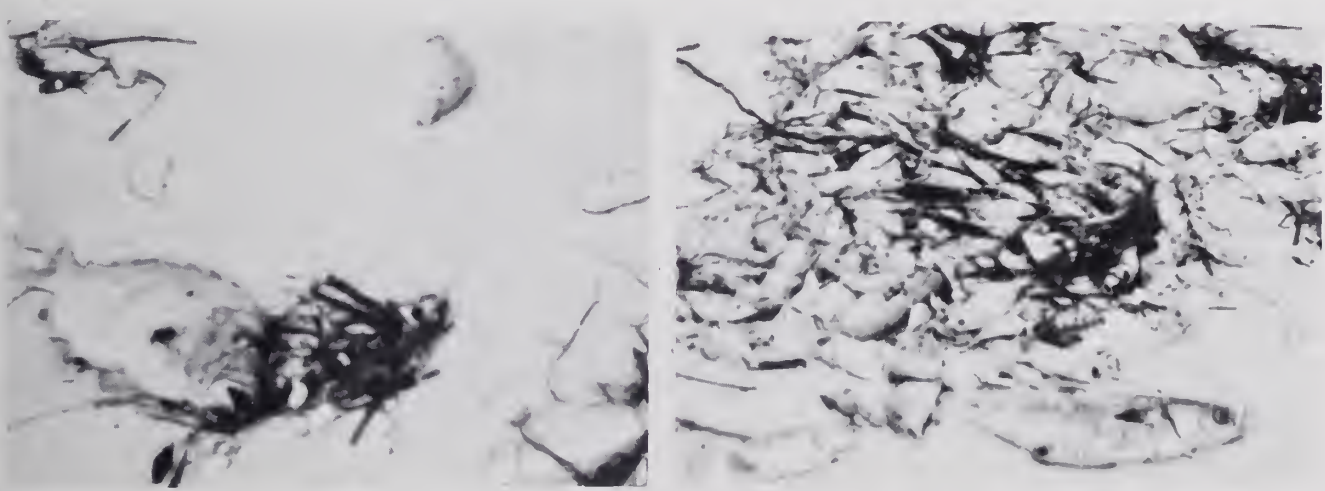


Fig. 2.—Fish kill at Boca Grande, November 1973. (Courtesy Frederic N. Silverman, M.D.)

mollusks accumulate and store toxin and, when consumed, can cause illness and sometimes death. Fortunately, symptoms from the ingestion of **G. breve** are usually mild; fatalities have not been recorded. A sequence of usual symptoms have been well-documented in the human: tingling sensations in mouth and extremities beginning within 30 minutes after ingestion, ataxia and general motor incoordination, hot-cold flashes, slow pulse, pupil dilation, mild diarrhea, followed by recovery in a few days. Occasionally, manifestations during the acute phase may be more severe—even alarming. A relevant case history appeared in the December 1, 1973 issue of Morbidity and Mortality.

A 10-year-old boy who ate five clams became ill within 30 minutes. He experienced circumoral paresthesias, intermittent diplopia, dizziness, thirst, fatigue, nausea, and vomiting. A little later he exhibited disphonia, ataxia and weakness of the legs. Approximately four hours after eating the clams, he had a generalized convulsion and was admitted to a local hospital with persistent seizure activity. Following a respiratory arrest, he was unresponsive with dilated, reactive pupils and paralysis. Over the next four days he recovered completely.

Another set of symptoms has been noted from time to time on the west coast of Florida in association with fish kills and blooms of **G. breve.** I refer to complaints of acute eye irritation and upper respiratory distress by people living in homes at or near the beach. It was particularly marked during the bloom of the winter of 1972. Winds and currents were favorable so that the Red Tide moved southward and through the Keys to reach the Atlantic Ocean. From here it traveled north as far as Palm Beach. On the coast it encountered the pounding surf of the Atlantic. In retrospect what happened has now been explained. At first there was talk of noxious gases emanating from the sea. These rumors turned out to be unfounded. We have spoken of **G. breve** as a naked dinoflagellate. Unlike its cousins on the northeast and northwest coast it has no protective coat of siliceous armor. Hammered by waves its body is disrupted; microscopic fragments liberated thereby pass into the foam of a seething surf. People who drove to the shore remained asymptomatic until they left their cars and walked on the beach. Symptoms were sudden in onset: profuse watering of the eyes and a burning sensation in the conjunctivae, severe nonproductive cough, a burning of the nose and copious rhinorrhea. Those who could not tolerate the symptoms and left the beach immediately experienced a rapid return to normality. The tougher souls who "stuck it out" had symptoms that lingered on for some time thereafter.

What About Prevention?

What, if anything, is being done to prevent PSP (paralytic shellfish poisoning)? The problem has been summed up in these words, "Today the problem of PSP control is not technological although it has technological aspects. It is mainly a problem of public education and requires new approaches." At present the coastal waters of Florida are being carefully watched by public health officials. When signs of an approaching bloom are detected, the areas are quickly posted with warnings of the danger. The sale of shellfish collected in these "closed" regions is prohibited by law. And still reports of cases of poisoning continue to appear in Morbidity and Mortality and sometimes in the daily news. All of these occur in small groups who, in disregard or in ignorance of the warnings, set out "to dig their own clams."

At the outset of this essay I stated reasons for a newly awakened interest in the Red Tide of Florida. Most of the rationality sprang from emotional feelings deep within the soul of an old, old fisherman. I have painted a picture of death, disease and devastating carnage. There is another side of the coin with which I should like to close. The world would be badly off without these abundant and widely distributed unicellular organisms of the sea. They are the sole source of nourishment for some of the largest mammals that have ever inhabited our planet, namely, the great whales. And sometimes they display signs of beauty that can be a joy to all mankind. I am thinking now of the phenomenon of luminescence, a property shared with the glowworm and the firefly. **G. breve** does not exhibit this property but it does occur with many of the species of Gonyaulax. On a September night some years ago while vacationing in my summer home close by the Atlantic Ocean, I was informed by a neighbor that the ocean that night was full of phosphorus. My wife and I went to take a look. Deeply moved by a beautiful vision, we watched and watched and watched. And, while beholding, words in the form of poetry emerged from the scene. As soon as we had returned to a place where pencil and paper were available, I made a record of the words. On this occasion I am happy to share them with you.

Phosphorescent diatoms, glimmering in the sea
Blazing forth in colors bright
In endless cadency,
Giving out both hope and light
To all humanity.

You were with me that night when we strolled to a sea
Phosphorescent with luminous glory.
The moon in late phase was not yet ablaze;
The ocean itself told the story.

A story of diatoms born long away;
Wafted by currents and tide,
'Til they came to consort at our summer resort
And dazzle the beach alongside.

A storm there had been in the waters off-shore.
The surf was majestic and high.
With reverberant boast the waves struck the coast
And blazed as they gasped a good-bye.

They blazed forth in colors of turquoise and jade
Illumining water and strand.
The aurora itself on its great northern shelf
Could not equal this sheer wonderland.

You were there to share with me the fulgor of night;
The glories of ocean and land.
You will not forget our heart's chansonette
In response to the algae and sand.

Algae, that glowed like the firefly at dusk
When roused by a hard pounding wave;
For, each lambent flame was there to proclaim
Both peace and the poise to be brave.

The poise to be brave and humble as well
In the wake of the wonders of earth;
Humble and calm like the words in a psalm;
Thus, the flesh and the blood find new birth.

Phosphorescent diatoms, glimmering in the sea
Blazing forth in colors bright
In endless cadency,
Giving out both hope and light
To all humanity.

References

Substantiation for most of the assertions detailed in this essay will be found in the following:

1. Steidinger, K. A. and Joyce Jr., E. A.: Florida Red Tides. Educational Series No. 17, Marine Research Laboratory, Florida Department of Natural Resources, St. Petersburg, Florida, April, 1973.
2. Music, S. I.; Howell, James T., and Brumback, C. L.: Red Tide; Its Public Health Implications, J. Florida M. A. 60:27-29 (Nov.) 1973.
3. Steidinger, K. A. and Ingle, R. M.: Observations on the 1971 Summer Red Tide in Tampa Bay, Florida. Florida Department of Natural Resources Marine Research Laboratory, St. Petersburg, Florida 33731. Environmental Letters, 3(4), 271-278, 1972.

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Colonoscopic Surgery

John P. Christie, M.D., FACS, FACG

Abstract: Colonscopic surgery is replacing abdominal surgery for removal of virtually all pedunculated polyps and most (80%) benign sessile polyps of all sizes.

Five patients are presented with barium enema radiographs demonstrating large (3-4.5 cm.) sessile polypoid lesions, each excised colonoscopically from all locations of the colon without complications.

Although virtually all pedunculated polyps can be excised endoscopically, the endoscopic appearance of sessile polyps determines whether or not they can be excised colonoscopically. Smooth, soft, lobulated, nonulcerated lesions are almost always benign and colonoscopically excisable regardless of size. Follow-up colonoscopic examination is most important in documenting complete excision of sessile lesions.

Endoscopically, ulceration is pathognomonic of malignancy. All malignant sessile lesions and certain larger benign sessile lesions, because of size or location, are unsuitable for colonoscopic polypectomy and should be removed by laparotomy.

Familiarity with the morphological criteria for endoscopic resectability and experience with the snare electrocautery techniques are most important; colonoscopic polypectomy is rendering abdominal surgery unnecessary for most (85%) colonic polypoid lesions.

Colonoscopic surgery is widely accepted and is replacing laparotomy for excision of most colon polyps. The feasibility, safety, economy and practicality of this relatively new technique is well documented.[1-3] Colonoscopy is not only for diagnosis and removal of pedunculated or smaller sessile polyps. Certain sessile polyps up to 6 cm. in size and even larger can be removed endoscopically, provided one is experienced with these techniques and the criteria which make larger sessile polyps suitable for safe and total endoscopic excision.[4,5]

Five patients are presented who had large (3-4.5 cm.), sessile, benign polypoid lesions which were managed by colonoscopic polypectomy. These examples document the principle that all colonic polypoid lesions be evaluated colonoscopically prior to performing laparotomy, since a significant number of large sessile lesions can be removed colonoscopically.[4,5]

Report of Cases

Case 1.—A 57-year-old woman was hospitalized with vague abdominal complaints (no bleeding or anemia). Sigmoidoscopy was unremarkable; barium enema revealed a 3.7 x 2.5 cm. polypoid filling defect in the right transverse colon (Fig. 1). Endoscopically, this lesion was soft, lobulated, sessile, and nonulcerated and was excised totally using the snare electrocautery device. Histologically, this was a benign adenoma. Colonoscopic examination three months later revealed no residual or recurrence.



Figure 1.

Case 2.—An 88-year-old woman was evaluated because of recent rectal bleeding. Barium enema demonstrated a 4.5 x 3.0 cm. lobulated polypoid defect in the proximal sigmoid colon area (Fig. 2). Colonoscopically, a large, soft, multi-lobulated, nonulcerated growth was identified and excised by "piecemeal" polypectomy technique.[6] Microscopically, this was a villous adenoma with in situ adenocarcinoma changes (noninvasive). The follow-up examination is pending.



Figure 2.

Case 3.— A 38-year-old woman was hospitalized with mild recent rectal bleeding. Sigmoidoscopy was unremarkable. Barium enema revealed a smooth, round, 3 x 2 cm. defect in the ascending colon (Fig. 3). Colonoscopy defined this as a soft, sessile polypoid growth with surface inflammation and erosion. It appeared both radiologically and endoscopically as a lipoma. Although lipomas are usually asymptomatic and not excised if obviously lipomatous, this lesion was excised because it might have been the source of bleeding. Six months later there has been no further bleeding.



Figure 3.

Case 4.—A 73-year-old woman with a past history of right colon cancer had regular barium enema examinations. In November 1973 this revealed a 4 x 2.5 cm. lobulated polypoid lesion in the proximal sigmoid colon (Fig. 4). Endoscopically, a lobulated, nonulcerated, sessile lesion was identified and was excised "piecemeal." Microscopically, it was a benign villous adenoma. Follow-up colonoscopy six weeks later revealed a normal-appearing erythematous polypectomy site. One year later a 1.2 cm. recurrence was documented and re-excised, and was again histologically a benign villous adenoma. There were no other colonic abnormalities. The CEA level was normal.



Figure 4.

Case 5.—A 63-year-old woman continued to have minor rectal bleeding following rubber-band ligation of bleeding internal hemorrhoids. Barium enema showed a 2.5 cm. sessile polypoid lesion in the lower descending colon (Fig. 5). The lesion was benign-appearing, slightly narrower at its base than in its broadest dimension and was excised colonoscopically. Histologically, it was a villoglandular adenoma. Follow-up examination six weeks later revealed no evidence of residual or recurrence.



Figure 5.

Discussion

Certain physical characteristics make a polypoid lesion suitable for endoscopic polypectomy:

Benign Appearance: Gross ulceration in a polyp is pathognomonic of invasive cancer in my experience and warrants colectomy with regional node resection. A smooth or lobulated, nonulcerated polypoid lesion, visualized in its entirety, is most often benign (see Size and Location below) and is usually endoscopically resectable. Softness by instrument palpation also suggests benignity. Firm, villous, nonulcerated lesions with an irregular surface are suspicious though usually benign lesions. A partial excision is occasionally feasible, providing a generous biopsy sample to assist with the decision as to method of removal. Colonoscopic polypectomy is advocated as a cure for benign sessile lesions. In the few instances where malignancy is revealed following colonoscopic polypectomy, colectomy should follow.

Size: Although size is not a limiting factor with pedunculated polyps, it is a limiting factor with certain larger sessile lesions; the greater surface area requiring electrocoagulation increases the risk of complications. This is especially important when considering lesions above the peritoneal reflection where the bowel wall is just millimeters thick. Certain larger benign lesions can be removed "piece-

meal" (Cases 1, 2, 4).[4, 6] Larger sessile lesions do have a higher incidence of malignancy and are less likely to be colonoscopically resectable.[7]

Location: Location is also an important factor since sessile lesions in the right colon are more frequently malignant, frequently larger (benign or malignant), and therefore sometimes unsuitable for colonoscopic polypectomy. The method of removal of a polypoid lesion should be decided upon only after endoscopic visualization of the lesion. Technically, it is often easier to remove a sessile polyp from the ascending colon than from a fixed, angulated region of the sigmoid colon. Occasionally a larger firm lesion will be in a difficult area (instrument maneuverability), such as the inner aspect of the ascending colon at the hepatic flexure. Laparotomy is preferred for any sessile lesion where maneuverability is compromised.

Patient Factors: Although complications requiring laparotomy have occurred in only two of the 600 colonoscopic procedures in our experience, the decision whether or not to proceed with colonoscopic polypectomy is sometimes affected by the patient's cardiac and pulmonary history, and occasionally also by the rapport and understanding between the patient and the doctor.

Not all colonic polypoid lesions are suitable for endoscopic polypectomy. In experienced hands, virtually all pedunculated polyps and most sessile benign polyps can be excised from all locations of the colon.[2, 4, 6] From our experience with 464 consecutively encountered colon polyps, 400 were excised colonoscopically (86%), with 29 lesions (7%) revealed to be malignant.[4] In this series 20 sessile lesions were found to be unsuitable morphologically for safe colonoscopic excision either because of size, difficult position (instrument maneuverability), or suspected or proven malignancy. These 20 lesions were removed by laparotomy with nine lesions (45%) found to be malignant. While all pedunculated lesions and all smaller benign sessile lesions were colonoscopically excisable, more than one half of the larger (35 of 56) sessile lesions (2-6 cm.) were colonoscopically excisable.

Follow-up colonoscopy is most important particularly with sessile lesions to insure against residual or recurrence. Although I have not seen recurrence following excision of pedunculated lesions, there have been five patients in the sessile polypectomy group in whom residual or recurrent polypoid tissue was identified and re-excised at the follow-up colonoscopy procedure. Follow-up for sessile lesions consists of direct visualization of the area one to two months postoperatively, and again one year later.

Sessile colonoscopic polypectomies are more difficult than pedunculated polypectomies. Wolff and Shinya have emphasized the need for proficiency with diagnostic colonoscopy before undertaking polypectomy.[8] Expertise with diagnostic examinations is not instantly transferable to excellence at surgical applications. The apparent simplicity of endoscopic polypectomy can be deceptive.

As more interested physicians are trained and gain experience with these techniques, abdominal surgery for most colonic polypoid lesions will become obsolete.

References

1. Wolff, W.I. and Shinya, H.: Colonofiberoscopy, JAMA 217:1509, 1971.
2. Wolff, W.I. and Shinya, H.: Polypectomy via the Fiberoptic Endoscope, New England J.M. 288:975, 1973.
3. Christie, J.P.: Fiberoptic Colonoscopy-Diagnostic Value in 250 Consecutive Patients, Southern M. J. accepted for publication, May, 1975.
4. Christie, J.P.: Which Colon Polyps Should be Excised? presented at GI section of Southern Medical Association meeting, Miami, Nov. 18, 1975, submitted for publication.
5. Shinya, H.: The Application of Colonoscopy of the Diagnosis and Management of Patients with Carcinoma of the Colon, presented at Am. Coll. Gastro. meeting, Las Vegas, Oct. 20, 1975.
6. Wolff, W.I. and Shinya, H.: Modern Endoscopy of the Alimentary Tract, Curr. Prob. Surg., Year Book Med. Publ., Chicago, Jan. 1974.
7. Wheat, N.W. and Ackerman, L.V.: Villous Adenomas of the Large Intestine, Ann. Surg. 147:476, 1958.
8. Shinya, H. and Wolff, W.I.: Colonoscopic Polypectomy: Technique and Safety, Hosp. Practice, 10:71, Sept. 1975.

▶ Dr. Christie, South Miami Hospital, South Miami 33143.

It is often easier to fight for one's principles than to live up to them.

Adlai Stevenson

Editorial Comment

This review by one man of his own experience with colonoscopic surgery is impressive—but I have some concern regarding its publication in the JFMA. In candor, I feel that Dr. Christie is the most experienced colonoscopic surgeon in Florida, possibly south of New York. He spent six months training in this technique with H. Shinya in New York after completing surgical residency. He is skilled and excellent but I think the paper's simplistic and dogmatic statements may encourage other surgeons and physicians, less skilled, less trained, less experienced, to perform procedures with considerable more morbidity and mortality than his.

Pedunculated polyps can be removed through the colonoscope but some not so easily. There can be burns of the wall followed by perforation and bleeding, but I agree in general that this technique promises to displace colonotomy in **skilled hands.** The **sessile** lesions pose much more controversy for the following reasons: (1) contour defects can be CA and require resection, (2) perforation, incomplete removal and bleeding are more often a problem, (3) few of our physicians in practice have the experience to know how to make the judgment as to what lesions to tackle and how much to remove. Repeat colonoscopic procedures are not inexpensive — diagnostic colonoscopy costs over $250 per procedure. If one undergoes two or three procedures it is not "economical."

The major reluctance I have is that this is a new technique acquired by only a **few** men. It is difficult to get training and experience in this field. I fear that untrained physicians will buy or have hospitals buy colonoscopes — and use them — before they have mastered the technique. I imagine that when T.U.R. was first introduced to urology that similar problems arose. I would have Dr. Christie emphasize his caution, advising mastery of the technique for pedunculated lesions **before** any attempt is made to treat sessile lesions. I'd rather our general surgeons continue to resect sessile lesions, when needed, than burn holes in the colon to be "au courant." Perhaps a companion note regarding the way our men can get training would be in order.

In summary, I think it is great that Jack Christie can do these procedures so safely and artfully, but I doubt that the readership of our Journal can follow suit. It is a bit too dogmatic for my taste. The text also speaks of follow-ups or "pending" or "six weeks" — that is hardly an adequate way of assessing this slow growing type of lesion.—Chester Cassel, M.D., Miami.

Not until the creation and maintenance of decent conditions of life for all men are recognized and accepted as a common obligation of all men . . . shall we . . . be able to speak of mankind as civilized.

Albert Einstein

The Dizzy Patient
ENG, Yes or No?

Dennis Agliano, M.D. and Herbert A. Cox, M.S.

Abstract: A schematic approach for evaluating the dizzy patient is presented. The practicing physician should be aware of existing techniques and order tests that will aid in the localization and treatment of vertigo. The importance of electronystagmography in evaluating dizziness is emphasized with classifications of vertigo and some representative etiologies included.

The use of electronystagmography (ENG) in otoneurological practice has made possible a clearer differentiation between various pathologies affecting the auditory, vestibular, and central systems. Also, the advent of sophisticated ENG instrumentation has greatly decreased the time and complexity of gathering accurate information. More importantly, however, ENG enables the physician to better his treatment of the dizzy patient, and provides an objective record which can be used in medicolegal cases involving the vestibular system, or in following a patient's progress.

Though the use of ENG is becoming more prevalent in clinical practice, it is surprising to find that many in the medical field are not familiar with the procedure and its importance to clinical diagnosis. Though this presentation is not intended as an in depth study of ENG interpretation and techniques, a brief overview of information obtained from the procedure is worth mentioning.

Electronystagmography is a technique of graphically recording electrical changes produced by nystagmus (the electrical potentials existing between the retina and cornea). This procedure enables the clinician to observe and record nystagmus which otherwise may be suppressed by ocular fixation upon routine physical examination. With ENG it is now possible to evaluate such abnormalities as positional vertigo and vestibular neuronitis. It may also be used to supplement other tests in the diagnosis of Meniere's disease, acoustic neurinomas, and central pathologies occurring in the brain stem, cerebellum, or in the cerebral hemisphere. Quite naturally, a full audiological evaluation is often included in the "dizzy work-up" as specific pathologies affecting the vestibular periphery may impinge on the auditory system as well (e.g., Meniere's disease).

One very important use of ENG is determining if a patient's dizziness is organic or of a nonorganic origin. In our clinic ENG is done routinely on Workmen's Compensation examinations in which dizziness is a complaint, or in cases of trauma by accident. If one has objective information such as a graphic recording of nystagmus on a patient complaining of vertigo, there can be no doubt as to its importance in medicolegal cases.

More often than not, however, patients complaining of vertigo are not fully evaluated even after the use of medications such as antihistamines, antiemetics, anticholinergics, and vasodilators fail to give relief. In such instances when the vertiginous symptoms continue, it is important that the patient be further evaluated.

NEURO-OTOLOGIC WORK-UP

We do not intend to give a detailed description of the neuro-otologic work-up for vertigo but rather to offer an approach we feel is accurate, objective, and avoids mislabeling a patient's complaint of vertigo as nonorganic when, in fact, there is a pathological problem. To assume that a dizzy patient's problem is functional because he/she has not responded to one or two courses of antivertiginous medications is not proper and, in fact, may be considered negligence if an acoustic neurinoma or brain tumor is missed.

Quite simply, the aim of the neuro-otologic work-up is to localize the lesion and then treat it appropriately. We classify vertigo as central, peripheral, or nonlocalizing (Table 1). Central vertigo is produced by neurologic disease, while peripheral vertigo is produced by otologic disease in most instances. Cardiovascular diseases commonly produce both central and peripheral vertigo and are often nonlocalizing. In addition, we must be mindful that

Table 1.—Classifications of Vertigo With Some Representative Etiologies.

PERIPHERAL (Otologic)	CENTRAL (Neurologic)
Meniere's disease	Multiple sclerosis
Benign paroxysmal positional vertigo	Concussion
Vestibular neuronitis	Vascular insufficiency syndrome
Eustachian tube dysfunction	Brain tumor
Labyrinthine concussion	Migraine
Temporal bone fracture	Epilepsy
Infection (inner or middle ear)	Increased intracranial pressure
	cervical vertigo

NONLOCALIZING
Cardiovascular (arrhythmia, embolism, postural hypotension, circulatory insufficiency)
Hypoglycemia
Myxedema
Syphilis
Fluid-electrolyte imbalance

hypoglycemia, myxedema, syphilis, and fluid electrolyte imbalance may present as dizziness and appropriate tests should be ordered. These latter disorders may be present even in the face of normal ENG findings. Rarely, ocular diseases are responsible for vertigo, however, these are usually easily diagnosed.

There are many diagnostic tests that can be ordered for the dizzy patient. Our objective should be to arrive at a diagnosis as simply as possible without subjecting the patient to the entire spectrum of tests if it is not necessary. First, a good history and physical examination are obtained (Tables 2 and 3). This determines which one of the steps we will pursue in the evaluation process (Fig. 1).

Table 2.—Procedures in History and Physical Examination.

HISTORY

R/O trauma, ototoxic drugs, recent brain or ear surgery, illness, alcoholic intake, medications, epilepsy.

PHYSICAL

General (BP, cardiovascular, endocrine)
Ocular (fundi, diplopia, nystagmus, vision)
Otologic (tuning forks, eustachian tube dysfunction, middle ear)
Neurologic (cranial nerves, cerebellar function test, gait)

Table 3.—Differential Diagnosis of Central and Peripheral Vertigo.

	Peripheral	Central
Onset	Sudden	Insidious
Pattern	Episodic	Continuous
Sense of rotation	Frequent	Infrequent
Severity	Intense	Seldom intense
Duration	Minutes to hours	Days to months
Influence of head movement	Marked	Slight
Tinnitus and/or hearing loss	Common	Rare
Cranial nerve and/or long tract involvement	Rare	Common

If our impression is that we are dealing with central nervous system disease, then we seek neurological

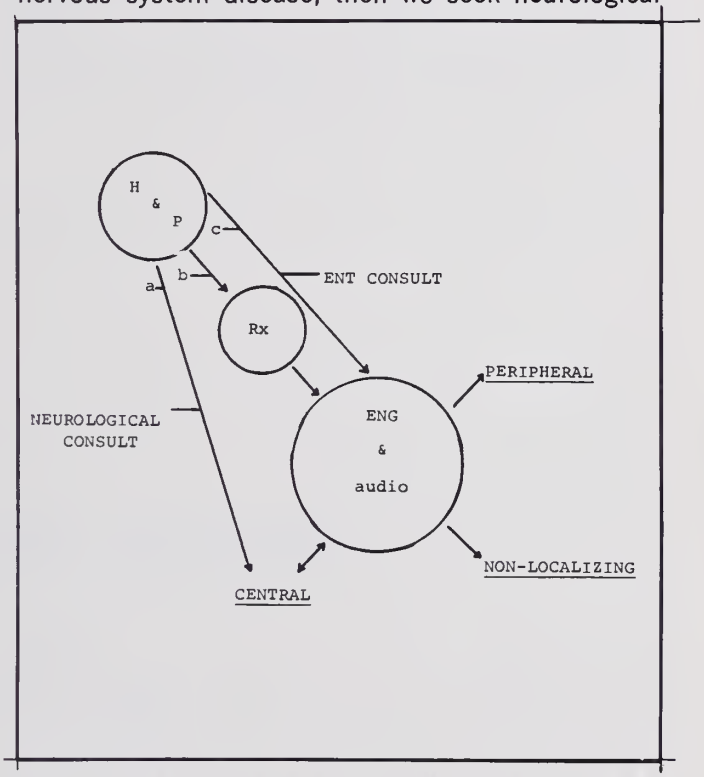


Fig. 1.—Schematic representation of the dizzy work-up.

Table 4.—Tests to Consider With Positive Neurologic Examination or Central Findings on ENG.

Skull x-rays
EEG
Brain scan or CT scan

Polytomography
Lumbar puncture

Myelogram
Arteriogram
} —(only with neurological consult)

consultation for specific testing (Fig. 1(a) and Table 4.) An ENG should also be considered in this diagnostic battery. If our impression is that we are dealing with a labyrinthine disorder or if we are uncertain of the etiology of vertigo, then we strongly advise obtaining an ENG and audiological evaluation as the initial diagnostic step (Fig. 1(c). This not only gives us a baseline on which to measure future progress, but may localize the lesion. A nonlocalizing finding on ENG should direct our thoughts to lesions that cause a more generalized disturbance. If we choose to treat the patient, but find that he/she does not respond to an adequate trial of medications, then we should continue the diagnostic work-up (Fig. 1(b).

Comment

We have presented a short but systematized work-up for the dizzy patient in which ENG plays an integral part. We do not imply that it should be done at the exclusion of other tests, especially in regards to neurological disease. We do feel that it is extremely helpful in the diagnosis of labyrinthine problems, and as a screening procedure in those cases where vertigo presents with a negative neurological examination. It also forms the basis for a permanent record which is objective and retestable.

References

Coats, A. C.; The Diagnostic significance of Spontaneous Nystagmus as Observed in the Electronystagmographic Examination, Acta Otolary., 67: 33-42, 1969.

Coats, A. C.; Central Electronystagmographic Abnormalities, Arch. Otolary., 92: 43-53, 1970.

Coats, A. C.; Electronystagmography: A Compendium, Baylor College of Medicine, 1200 Moursund Avenue, Houston, Texas, 43-54, 1972.

Cogan, D. G. and Loeb, D. R.; Optokinetic Response and Intracranial Lesions, Arch. Neurol. Psychiat., 61: 183-187, 1949.

Davidoff, R. A., Atkins, A.; Anderson, P. J. and Bender, M. B.: Optokinetic Nystagmus and Cerebral Disease, Arch. Neurol. 14: 73-81, 1966.

Dix, M. R. and Hallpike, C. S.: Pathology, Symptomatology and Diagnosis of Certain Common Disorders of the Vestibular System, Proc. Roy. Soc. Med. 45: 341-354, 1952.

Harrison, M. S.: Notes on the Clinical Features and Pathology of Post-Concussional Vertigo, With Special Reference to Positional Nystagmus, Brain. 79: 474-482, 1956.

Hart, C. W.: Ocular Fixation and the Caloric Test, Laryngoscope 77: 2103-2114, 1967.

Jung, R. and Kornhuber, H. H.: Results of Electronystagmography in Man: The Value of Optokinetic, Vestibular and Spontaneous Nystagmus for Neurologic Diagnosis and Research; In M B. Bender (Ed.), The Oculomotor System, Harper & Row, New York, 428-482, 1964.

Rubin, W. and Norris, C.: Electronystagmography: What is ENG? Charles C. Thomas, Publisher; Springfield, Illinois, 1974.

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Case Report

Klinefelter Syndrome Associated With Atrial Septal Defect and Prolapse of the Mitral Valve

David Murray, M.D., Robert Bucher, M.D., Alan B. Miller, M.D.,
Juan L. Roque, M.D. and Simon Doff, M.D.

ABSTRACT: Congenital heart disease (CHD) is a relatively common occurrence among individuals with sex chromosomal abnormalities.

Here we report a case of Klinefelter syndrome (XXY) with associated ostium secundum atrial septal defect (ASD) and prolapse of the mitral valve (PMV).

CASE REPORT

The patient, a 32-year-old mentally retarded black male referred for evaluation of a cardiac murmur, had no complaints pertaining to the cardiovascular system. Family history was positive for tall stature with three siblings and two parents over six feet in height. There were no family members with dislocated lens, mental retardation, or cardiac abnormalities. Physical examination revealed a tall (74 inches), thin, black male with an arm span of 76 inches, blood pressure 150/100, pulse 90 with frequent premature beats. There was no evidence of dislocation of the lens or retinal abnormality. The palate was normal. Jugular venous distention was present at 30° with equal A and V waves and a positive hepatojugular reflux. Inspection of the chest revealed a prominent carinatum deformity. A right ventricular heave and palpable second heart sound were present along the left sternal border. The first sound was normal. The second heart sound was widely split and fixed with an accentuated pulmonic component. A grade II-III/VI systolic ejection murmur was present along the upper left sternal border, with radiation to the left infraclavicular region. A grade II/IV blowing nearly holosystolic murmur was noted at the apex with radiation to the axilla. Beard, pubic, and axillary hair were scant. Bilateral gynecomastia was present. The testicles were descended bilaterally, firm and small of approximately 1/2 cm in diameter.

Laboratory Data

Electrocardiogram revealed right atrial and right ventricular enlargement, with frequent PAC's and PVC's. Chest x-ray showed right ventricular enlargement and increased pulmonary flow. Homocystinuria was ruled out by amino acid chromatography on blood and urine. Serum testosterone was diminished at 274 ng/100 ml (normal 300-1000); with elevated levels of follicular stimulating hormone (FSH) 88 mIU/ml (normal 5-25), and luteinizing hormone (LH) 84 mIU/ml (normal 5-25). A positive buccal smear for sex chromatin with 28% Barr bodies present in 100 cells and a 47-XXY chromosomal pattern (Fig. 1.) in 50 cells from a peripheral lymphocyte culture confirmed the diagnosis of Klinefelter syndrome. Cardiac catheterization revealed a step-up in oxygen content at the atrial level consistent with a L-R shunt calculated at 78% (4.8:1). The left ventriculogram confirmed mitral valve prolapse (PMV) with a normal outflow tract (Fig. 2).

From the Department of Medicine, University Hospital of Jacksonville, Jacksonville.

Hospital Course

The patient was taken to the operating room where a large ostium secundum ASD was found and repaired. The postoperative course was complicated by atrial arrhythmias, which responded promptly to beta blockade therapy with propranolol.

Discussion

Congenital cardiac abnormalities are not as common in Klinefelter syndrome as in other disorders of sex chromosomal constitution such as Turner syndrome (XO). However, atrial septal defects (ASD) and several other abnormalities have been noted previously.[1] While this may represent a chance association on a purely statistical basis, the presence of cardiac disease can have a profound effect in patients with Klinefelter syndrome.

The association of mitral valve disorders with ASD is well established. A primum type defect was excluded in our patient on the basis of the left ventriculogram and confirmed at surgery. The combination of secundum ASD with PMV has been noted with increasing frequency.[2,3] The clue to the diagnosis of the mitral valve abnormality is in the physical examination. An apical murmur of mitral regurgitation in a patient with clinical evidence of a secundum ASD with L-R shunt should suggest associated PMV, which introduces the risk of infective endocarditis as well as exercise-induced arrhythmias.

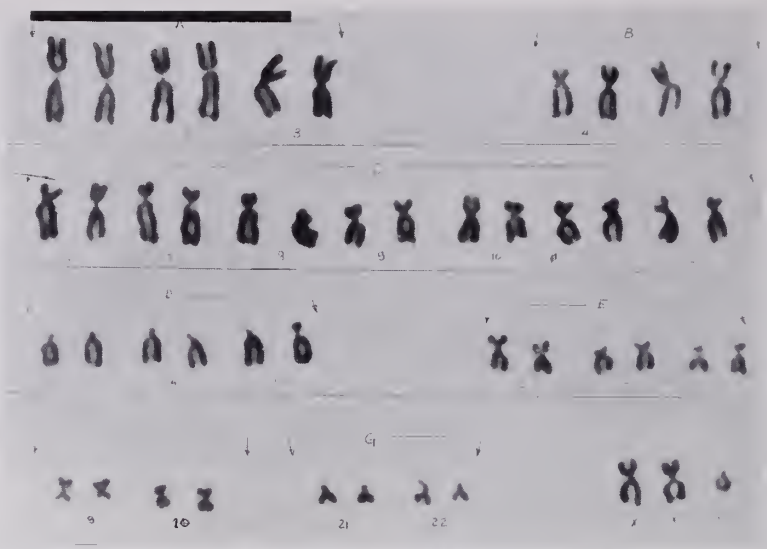


Fig. 1.—Chromosomal analysis demonstrating the 47 XXY abnormality.

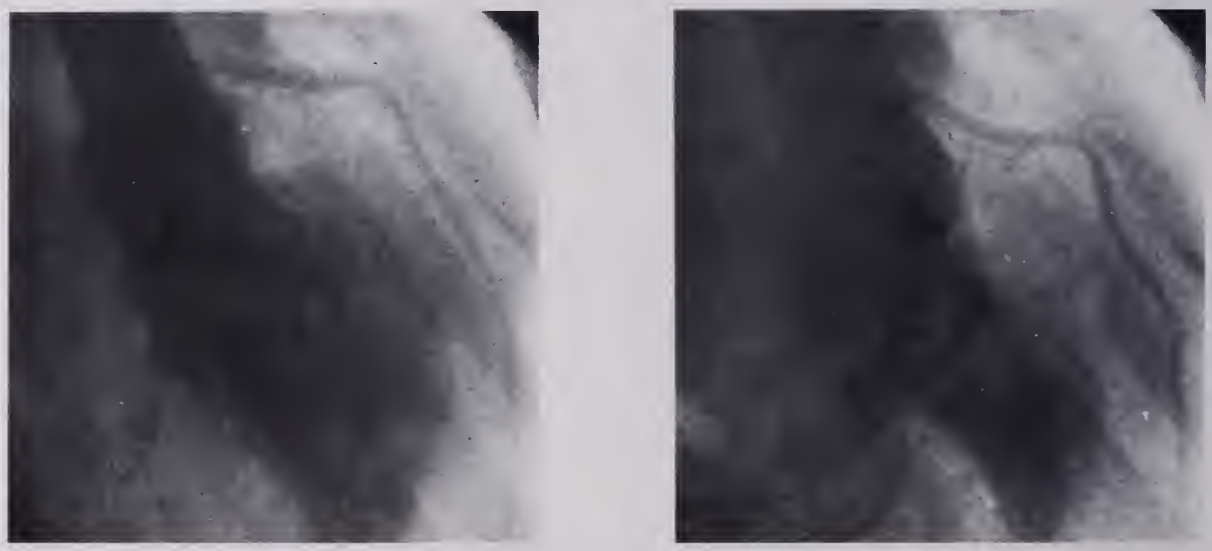


Fig. 2.—Left ventriculogram in the 30° right anterior oblique projection in diastole (A) and in systole (B). Posterior billowing of the deformed posterior leaflet of the mitral valve can be seen. The left ventricular configuration durin systole is peculiar, which has been described in PMV disorders. The aortic outflow tract appears to be normal.

References

1. Rosenthal, A.: Cardiovascular Malformations in Klinefelter Syndrome: Report of Three Cases, J. Pediat. 80:471, 1972.
2. MacDonald, L., Harris, A., Jefferson, K., et al: Association of Prolapse of Posterior Cusp of Mitral Valve and Atrial Septal Defect, Brit. Heart J. 33:383, 1971.
3. Pocock, W. A., and Barlow, J. B.: Association Between Billowing Posterior Mitral Leaflet Syndrome in Congenital Heart Disease, Particularly Atrial Septal Defects, Am. Heart J. 81:720, 1971.

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Drug Utilization Review is part of the Medicaid drug program in your state. The goal is to assist in the delivery of rational drug therapy for Medicaid patients and reduce the over all cost of the Medicaid drug program.

How can Drug Utilization Review do that?
It is done by reviewing Medicaid drug use and sharing the results of the review with those doctors and pharmacists involved in treating the patient. When a Medicaid prescription claim is processed, a computer records who received the drug, who prescribed it, who dispensed it, and what kind of drug it was. Once a month, the computer compares the drug use records of each patient with several criteria, such as kinds of drugs used, amounts purchased, number of doctors visited, and so on.

When a patient's drug use goes beyond any of the criteria, the computer prints a report for review by the Drug Utilization Review Committee.

Just who is the Drug Utilization Review committee?
It is a group of fellow health care professionals—physicians and pharmacists from your area. Committee members are selected from nominations made by your local medical and pharmaceutical associations. Each member serves for 1 to 3 years. You may be invited to serve on the committee at some time.

What does the Drug Utilization Review committee do?
The committee reviews patient drug histories showing drug use patterns which exceed criteria set for the program. If the questionable pattern appears to be minor or temporary, the committee may decide to take no further action.

If the situation is more serious, the committee will write to the doctors and pharmacists involved to advise them of the potential problem. For example, the records might show that a patient is going to several doctors to get prescriptions for the same drug. The committee would advise each of the doctors of this practice. In another case, the committee might recommend that a doctor prescribe maintenance drugs in larger, more economical quantities, if the patient's condition warrants it.

Are you trying to tell me how to treat my patients?
Not at all. Your patients' treatment is in your hands, where it belongs. All Drug Utilization Review does is give you information about your patients' drug use that hasn't been available before. The committee can't dictate the kind of drug therapy you use, and wouldn't want to if it could.

What do I have to do if I get a letter about a patient?
The committee will ask you to review your records to see if the situation described in their letter is with your knowledge and conforms with your diagnosis and treatment. If so, please advise the committee of your diagnosis and treatment plan so they'll know that the drug use is appropriate and won't send additional letters in the future.

If the situation is not called for by your treatment plan, the committee asks that you review the situation and make those changes you feel are necessary. In all cases, they try to make it as easy as possible for you to respond to the committee and use the information provided.

How can a physician find out more about the Drug Utilization Program?
A pamphlet which explains the Drug Utilization Review program in detail is available or a visit to your office by a staff member can be arranged upon request. A speaker or a color/sound film can also be provided for local medical societies or other groups interested in further information about the program. Your peers who are members of local peer review committees will be glad to explain the program personally or answer any questions. If you will write or call PAID Prescriptions, any information requested will be provided including the names of committee members in your local area.

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SPECIAL ARTICLES

Multimillion Dollar Adjustment in Workmen's Compensation Fees

A Major FMA Accomplishment

James F. Richards Jr., M.D.

The Florida Medical Association pursued a long and difficult course in achieving finally a 32% across-the-board increase in the Workmen's Compensation Medical and Surgical Fee Schedule Christmas Eve 1975, effective March 1, 1976. It is the largest increase ever granted and amounts to some $19 million a year increase in monies that will be paid to physicians in Florida for services rendered to Workmen's Compensation patients, assuming the same workload in the next 12 months as there was in the past 12 months. It is estimated approximately 3,500 to 4,000 physicians participate in Workmen's Compensation care.

On April 9, 1975 the FMA, in compliance with the State Administrative Procedures Act, filed a petition with the Florida Division of Labor, Department of Commerce, Bureau of Workmen's Compensation requesting that the Workmen's Compensation Medical and Surgical Fee Schedule be updated to comply with the Workmen's Compensation law which states that fees charged shall be ". . . limited to such charges as prevail in the same community for similar treatment of injured persons of like standard of living . . ."

Following this, a meeting was held with the Workmen's Compensation Advisory Council on May 19, 1975 in Tallahassee. An additional meeting, with representatives of the Bureau of Workmen's Compensation, was held June 16, 1975 in Jacksonville. Subsequently, three public hearings—July 31, 1975, August 25, 1975 and December 18, 1975—were held to review the Workmen's Compensation Medical and Surgical Fee Schedule. At these hearings, FMA presented testimony and evidence to prove the Fee Schedule being paid was woefully lower than it should be. The FMA maintained throughout its testimony that usual and customary should be considered the 90th percentile. We had as evidence the millions of services paid under Medicare the previous year in the State of Florida at the 75th percentile and could fairly well estimate the 90th percentile based upon a formula developed by our statisticians. To sustain that evidence, we had at our disposal the Relative Value Study survey of Sarasota County, which was done preparatory to surveying the entire State for purposes of updating the Florida Relative Value Study. The amount of evidence was overwhelming and after the FMA's major testimony in July and the opponents' meager testimony, with absolutely no evidence, in August, we were very much surprised when the entire petition was rejected out of hand.

In accordance with the Administrative Procedures Act, the FMA appealed the decision to the First District Court of Appeals. However, by joint stipulation and at the request of the Department of Commerce, Bureau of Workmen's Compensation, we recalled the case for a third and final hearing December 18, 1975.

There were many loyal FMA members who came forward and offered testimony during the July and August hearings. At the December hearing, representatives of the United Physicians and Dentists of Florida introduced a recommended fee schedule based on a telephone survey of a few physicians from each specialty in the Dade and Broward County areas. It was pointed out at the public hearing by the Hearing officer that this was not a statistically valid sampling of physicians, but rather represented

Dr. Richards, of Orlando, is Chairman of the FMA Council on Medical Economics.

an attempt by the UPDF to request a lesser increase than the FMA, in hopes that a lesser increase might be approved. Their testimony was heard politely by the Hearing officer, but meticulously picked apart. The transcript of that public hearing is available for anyone's scrutiny. The Department did not consider the testimony of the Union in arriving at the 32% increase on December 24, 1975. The 32% is based upon the increase in the Medical Care Component of the Consumer Price Index between April 1971, and July 1975. April 1971 was the date the FMA last petitioned for an increase in the fee schedule resulting in a relatively small increase effective July 20, 1972.

In the February 24, 1976 issue of "News Report," a newsletter published by the American Federation of Physicians and Dentists, and captioned VICTORY IN FLORIDA stated, "After the Florida Medical Association's petition for an increase in compensation fees was denied by the Division of Labor, United Physicians and Dentists of Florida prepared and submitted to the Bureau of Workmen's Compensation in Tallahassee a Fee Schedule. This schedule was compiled for practitioners and specialists by using their own union members to work out Usual, Customary and Fair Fees for Compensation Cases. From direct efforts and testimony at the Division of Labor Hearing in Tallahassee the UPDF was able to obtain a 32% overall increase in compensation fees effective March 1, 1976."

This statement is a totally inaccurate and untrue account of the increase in the Florida Workmen's Compensation Medical and Surgical Fee Schedule. That newsletter was mailed to physicians and dentists nationwide. It is quite obvious that this attempt by the UPDF to take credit for the increase is a total misrepresentation by the Union for purely political reasons and should be exposed for what it is. We have requested the AMA to publish such an exposure article.

The new Workmen's Compensation Schedule has been printed and except for anesthesiology, contains dollar figures. The only conversion factor is that for Anesthesia multiplied times ten minute intervals. Inequities remain. We obtained the increases that we requested for Pathology and Radiology for the most part. We also obtained the increases for non-operative or medicine category. However, the Bureau still does not recognize anything more than a Brief Initial Office Visit and Hospital Visit. They were not willing to recognize that there is such a thing as Limited, Intermediate or Comprehensive Examination. Furthermore, the increases sought for Anesthesiology and Surgery were only partially obtained.* It is hoped that working through the FMA members on the Advisory Committee to Bureau of Workmen's Compensation during the coming year, we can accomplish some adjustment of these inequities and hopefully make arrangements for an annual updating of the Medical and Surgical Fee Schedule without the cost and consumption of time required of FMA in petitioning for such increases.

*The Bureau also refused to recognize the five-digit coding and nomenclature predominantly used nationwide and in Florida since 1971.

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When you can, always advise people to do what you see they really want to do, so long as what they want to do isn't dangerously unlawful, stupidly unsocial or obviously impossible. Doing what they want to do, they may succeed; doing what they don't want to do, they won't.

James Gould Cozzens

Annual Meeting Highlights

(The complete text of the proceedings of the House of Delegates will be printed in the July issue of The Journal)

May 5-9 — Hollywood

The Professional Liability Insurance crisis continued to be a major issue of discussion at the 102nd Annual Meeting of the Florida Medical Association, May 5-9, 1976. FMA's House of Delegates assembled at the Diplomat Hotel in Hollywood expressed support and satisfaction with the Association's ten point professional liability legislative package currently being considered by the Florida Legislature. Outgoing President, Dr. Vernon B. Astler, in a report to the House of Delegates discussed the efforts of the FMA in pursuing as vigorously as possible passage by the legislature of tort reforms to include the following:

1. Recovery of defense cost
2. Implementation of pre-trial mediation panels
3. Limitation on general damages
4. Structured pay-out of future damages (non specific)
5. Definition of medical professional negligence
6. Application of collateral sources in settlements as a direct offset
7. Definition of medical expert witnesses
8. An absolute two year statute of limitations
9. Prohibit use of res ipsa loquitur doctrine in professional negligence actions
10. Limitation of attorney's contingency fees

Dr. Astler emphasized that, "unless we have the continued support of physicians at the community level no effort will be successful in the legislative arena." He thanked each of them for their individual contributions to the program. The question of the constitutionality of the pre-trial mediation panels as enacted by the 1975 Legislature has been ruled constitutional in unanimous decision by the Florida State Supreme Court. The Court has not ruled on Florida Bar's petition setting a limit on contingency fees for attorneys. (The FMA has filed a brief requesting the Court to modify the Florida Bar's position by lowering the limits.)

Through the able assistance of James F. Richards, M.D., Orlando, Chairman of FMA's Council on Medical Economics, with support of legal counsel, the State of Florida was petitioned and FMA was successful in obtaining an adjustment for physicians' fees under Workmen's Compensation. An approximate increase of 32% across the board for physicians was achieved. This increase came after a period of almost five years with no adjustment in physicians' fees. This will mean an annual increase of approximately 19 million dollars for over 4,000 physicians currently rendering services under Florida's Workmen's Compensation Program.

The House of Delegates received a report from Dr. Astler regarding the use of the special assessment voted upon by the House of Delegates at its meeting in February for both professional liability legislative action and also public relations activities. In addition to expert legal and other professional counsel utilized for the Professional Liability Legislative Program, the FMA Capital Office has been expanded with George Palmer, Jr., as Manager and Nancy Moreau as Legislative Analyst, and additional secretarial support to assist the Director of Legislative Affairs, Mr. Scotty Fraser. In addition, an office building has been purchased and renovated which is strategically located on the corner of College and Adams Street approximately one block from the Capitol Building. In addition, a full-time staff has been added for the Association's public relations program to implement a long range and indepth public relations program to enhance the image of the practicing physician in the state.

Mr. Roy Pfautch, President of Civic Service, Inc., an acknowledged authority in the field has been retained as consultant to the Association for public relations and Mr. Jan Fisher and Mrs. Carolyn Kenyon have been added to the FMA Staff as Director and Assistant Director respectively of FMA's Public Relations Department. They are both actively pursuing statewide implementation of this program.

The Association's highest honor, the Certificate of Merit, was awarded posthumously to Dr. Robert E. Zellner of Orlando for his dedicated community and professional leadership throughout his life on behalf of the public and the medical profession. Dr. Zellner's untimely death on February 23, 1975 deprived Florida and the medical profession of one of its most distinguished and esteemed leaders. The House of Delegates awarded the Association's Certificate of Appreciation to two physicians—Dr. Wesley S. Nock, of Miami for his acknowledged and meritorious service to the people of this state and most especially to the children of Florida and to the profession of medicine, and to Dr. Thomas E. McKell of Tampa for his many contributions to the people

of Florida and to the profession of medicine. The A. H. Robins Company Award for "Outstanding Community Service by a Physician" was presented to Gordon Henry McSwain, M.D. of Arcadia, whose life has been dedicated to public service, civic improvements, protection of the environment and the faithful practice of medicine.

The Association awarded its Distinguished Layman's Award to U. S. Congressman, Paul G. Rogers, Palm Beach, for his innovative and continuing service to the citizens of Florida and the United States as Congressman, a position from which he has played a leading role in contributing to the advancement of the ideals of the medical profession.

Jack A. MaCris, M.D., St. Petersburg surgeon, was installed as President on the final day of the convention succeeding Vernon B. Astler, M.D. of Boynton Beach. He will be succeeded next year by Dr. Louis C. Murray of Orlando. In addition, Dr. Richard S. Hodes of Tampa was re-elected to a second term as FMA Treasurer. Robert E. Windom, M.D., Sarasota, was elected as FMA Secretary. O. William Davenport, M.D., Miami, was elected as Vice President. Charles J. Kahn, M.D., Pensacola succeeds Dr. Louis Murray as Speaker of the House and Dr. Sanford A. Mullen of Jacksonville was elected as Vice Speaker. Dr. Vincent P. Corso of Miami was elected to a second term on the Association's Judicial Council and Dr. Joseph H. Davis, Miami was elected to fill out the unexpired term on the Council of Dr. William E. Straight.

Dr. MaCris announced council and committee appointments for the coming year. The following Council Chairmen were named: William W. Thompson, M.D., Fort Walton Beach, Judicial Council; James B. Perry, M.D., Fort Lauderdale, Legislation and Regulations; James F. Richards, M.D., Orlando, Medical Economics; J. Russell Forlaw, M.D., Boynton Beach, Medical Services; James L. Borland Jr., Jacksonville, Medical Systems; J. Lee Dockery, M.D., Gainesville, Scientific Activities; and John C. Fletcher, M.D., Tampa, Council on Specialty Medicine.

These Committee Chairmen were named: Louis C. Murray, M.D., Orlando, National Legislation; Charles K. Donegan, M.D., St. Petersburg, Relative Value Studies; Philip Cotton, M.D., Panama City, Health Insurance; William R. Stinger, M.D., Miami, Public Health; Robert P. Johnson, M.D., Tallahassee, Drug Abuse; Marvin S. Allen, M.D., Hollywood, School Health; R. Edward Dodge Jr., M.D., Inverness, Rural Health; Arthur L. Trask, M.D., Boynton Beach, Emergency Medical Services; Thomas E. McKell, M.D., Tampa, Foundations for Medical Care and PRO; Frank Hodnette, M.D., Pensacola, P.M.U.R.; Jerry F. Cox, M.D., Boynton Beach, Hospitals and Extended Care Facilities; Edward L. Farrar Jr., M.D., Orlando, Government Programs; Gerold L. Schiebler, M.D., Gainesville, Scientific Publications and Editor of The Journal; Yank D. Coble Jr., M.D., Jacksonville, Continuing Medical Education; J. Donald Wargo, M.D., Boca Raton, Medical Education; Luis M. Perez, M.D., Sanford, Allied Health Professions; Robert C. Palmer Jr., Pensacola, Voluntary Health Agencies; John M. Hamilton, M.D., St. Petersburg, County Medical Society Presidents. Special committees: Donald G. Nikolaus, M.D., Dunedin, Nursing Homes; Bernard Kimmel, M.D., West Palm Beach, Sports Injuries; James F. Richards, M.D., Orlando, Cost of Medical Care; and William J. Dean, M.D., St. Petersburg, Long-Range Malpractice Planning.

Convention registration total 2,688 including 1,753 physicians. There was strong interest in the Professional Liability Insurance issue and also the comprenhensive scientific program which enabled members to earn a full years' quota of mandatory credit in the Association's Continuing Medical Education Program.

The Scientific Exhibit attracted 31 attractive displays. First Place was awarded to "Stigmata of Respiratory Trac Allergies Usual and Unusual Signs", shown by Meyer B. Marks, M.D., Miami Beach.

In other important actions, the House of Delegates:

—Received a report from Dr. James W. Walker, President of PIMCO regarding the status of the Florida Medical Association's Professional Liability Insurance Trust. The plan now covers some 4,000 members of the FMA.

—Reiterated FMA's position that the Fifth Pathway to licensure in Florida is not in the best interest of the people of the state at the present time.

—Extended recognition and appreciation to Dr. Michael J. Pickering for his outstanding contributions to continuing medical education in Florida.

—Approved funding of two research grants by the Florida Medical Foundation totaling some $12,000 for "Screening for Hypertension in a Population of College Students at the University of Florida Student Health Infirmary," and "Electromyographic Studies of Patients with Scoliosis".

—Noted with pleasure that the Association's Committee on Medical Education would be working closely with the AMA's Curriculum Committee in planning for the AMA Winter Scientific Session to be held at Miami Beach in December 1977.

—Recommended that state agencies not hire non-physicians to practice medicine as defined in the Medical Practice Act FS458 for the diagnosis or treatment of mental or emotional disorders.

—Expressed opposition to legislation which would require mandatory uterine cytologic examinations, favored support of a voluntary program.

—Supported legislation requiring certification testing of EMT-II's and physician supervision in monitoring of those advanced life support components of the EMS system that would require a physician to be responsible for supervision through direct contact or by standing written orders.

—Approved continuing liaison with the medical staff of Florida's prison medical facilities to insure quality medical care to persons in these institutions.

—Recognized the continuing and vital role played by the Committee on School Health as the Medical Advisory Committtee to the Department of Education and the Health Program Office.

—Expressed strong support for the National Swine Influenza Vaccination Program and requested each county medical society to designate a committee to coordinate its members participation in this program with emphasis on mass immunizations in the physicians office.

—Approved FMA participation in a State Task Force on Rural Health to evaluate the need of medical services in underserved areas and suggest possible solutions to problems of providing health care in these areas.

—Commended the Board of Regents and the Community Hospital Education Council for their current and continued emphasis on primary care.

—Encouraged each county medical society to establish training programs for its members and to encourage their members to show proficiency in CPR.

—Approved continuing liaison and recognition of some eleven allied health professions and approved guest editorials in The **FMA Journal** from official representatives of the allied health professions when desirable and feasible.

—Approved continuing recognition of 12 Florida Voluntary Health Agencies.

—Resolved to request the AMA House of Delegates to request the Joint Commission on Accreditation of Hospitals to make no recommendations on hospital staff membership for podiatrists and other allied health professions and to leave this matter to the discretion of individual hospital staffs.

—Approved amendments to the FMA Bylaws to provide that any doctor of osteopathy who has satisfactorily completed an AMA approved internship or residency training program may be accepted into membership in the FMA upon certification by the secretary of his component county society as a member in good standing.

—Approved a statement of policy regarding coordination of legislative activity by specialty groups.

—Expressed opposition to the housing of criminals in mental institutions.

—Expressed the opinion that it is not the obligation of physicians to provide cost containment and medical care information to the U.S. Government.

—Endorsed the policy statement presented by Dr. Vernon B. Astler before the U.S. Congress regarding Florida's Position on National Health Insurance.

—Expressed enthusiastic support for the candidacy of Dr. Francis T. Holland of Tallahassee for the office of Vice President of the AMA.

—Expressed strong opposition to the cutback in fees for allowable charges for physician's services under Florida's Medicaid Program and expressed dismay at the mismanagement of the program.

—Adopted a resolution opposing the use of Social Security numbers as a universal number identifier.

—Expressed opposition to legislation which would grant limited licenses to practice medicine in Florida to retired physicians from other states.

—Endorsed legislation establishing standards for the operation of acupuncture clinics.

—Dispproved of the establishment of a School of Osteopathy in Florida.

—Opposed changes in Florida's antisubstitution laws which would allow generic prescribing without prior approval of the physician.

—Rebutted as completely inaccurate the claim of the United Physicians and Dentists that they were responsible for recent increases in Florida Workmen's Compensation Medical and Surgical Fee Schedule for physicians' services.

—Acknowledged with approval the Physician Recruitment Conference, which had been sponsored by FMA, to inform communities of problems associated with setting up practice in underserved areas.

—Endorsed the rules and regulations proposed by the Department of HRS setting minimum standards for home health care agencies.

—Approved co-sponsorship by the Florida Medical Foundation of an EMS Public Education Conference.

—Endorsed the basic concept of optimal care of catastrophic illness and injury for all Floridians and approved a statewide Conference on the identification of Needs and Standards for Critical Care.

—Adopted a policy statement regarding commercial medical information services.

—Expressed support for uniform accounting systems and public financial disclosure for hospitals and nursing homes.

—Approved recognition of the Foundation for Medical Care of the Big Bend Area of Florida, Inc. and of the West Florida Medical Foundation.

—Urged that each component county medical society make every effort to insure physician participation in state health planning activities in each of the HSA areas in Florida.

—Resolved to request that state and national legislators increase the time limit for pertinent response to proposed-rules and regulations to 90 days.

—Authorized exploration of possible establishment of a consortium composed of the private sector to serve as the manager of health data so as to insure the control of such data.

—Adopted criteria and procedures for implementing FMA's Continuing Medical Education Program.

—Recommended to the State Board of Medical Examiners that the actions of any nurse practitioner or nurse assistant not covered by the nurse practice act only be made under the responsible supervision of a qualified physician and that nurse practitioners not be allowed to bill for third party payments.

—Expressed concern about nursing homes and nursing home care and offered continuing assistance and cooperation with all interested parties in seeking ways to solve these problems and urged FMA membership to take a more active role in supervision of nursing home care in the state.

—Amended the FMA Bylaws to extend privilege of the floor to AMA General Officers and Past Presidents who are FMA members.

—Expressed appreciation to the Woman's Auxiliary for their many worthwhile activities in behalf of organized medicine and the betterment of health care in Florida.

—Encouraged the establishment of Woman's Auxiliaries to the county medical societies in any county where none currently exist and requested that each county medical society give guidance and support to the Auxiliary in their endeavors.

—Opposed legislation that would weaken the ability of the Board of Medical Examiners to carry out its functions.

—Opposed legislation which would require physicians to submit to patients an itemized statement understandable in laymen's terms of services rendered with a 14-day waiting period before payment by third parties.

—Opposed legislation which would grant hospital staff privileges to chiropractors.

—Adopted a position in favor of catastrophic health insurance funded by the private insurance sector and instructed FMA Delegates to the AMA to introduce and support this concept as the official position of the American Medical Association.

—Expressed strong opposition to legislation pending before the U.S. Congress regarding drug package inserts.

—Opposed any extension of nursing practice when such an extension might be detrimental to good patient care.

—Expressed support and confidence in the Board of Directors and the staff of Blue Shield of Florida.

—Expressed opposition to the 24-hour review in any form imposed by PSRO and requested the assistance of AMA in resisting implementation of this review.

Contingency Fees

David J. Lehman, M.D.

A great deal has been written concerning attorneys' fees in all civil liability cases including medical malpractice.

On November 19, 1975 the Florida Bar (Case #48384) petitioned the Supreme Court of Florida for "Amendment of the Code of Professional Liability."

A contingency fee is defined as "one contingent upon the recovery of money or other property by a client and the fee arrangement must be made by written contract signed by the client and by the attorney." This definition does not apply to criminal cases.

Any fee in which the contingent portion exceeds the following standard shall be presumed **clearly excessive** unless the contract would have been submitted to and approved by the Court as hereinafter provided:

a) 31⅓% of recovery if settled prior to the commencement of the suit.

b) 40% of the recovery at trial or if the recovery is settled after the commencement of the suit.

c) 45% of the recovery if the judgment of the trial court is appealed or postjudgment proceedings are required to enforce the same.

d) 25% of that portion of any recovery exceeding $500,000 at any stage of the proceedings.

However, if a contingency fee contract exceeds the foregoing standards because of unusual circumstances, the contract is submitted and **approved** by the presiding judge or designated alternate of any court in Florida in which any action for recovery under the contract is to be commenced.

The Florida Medical Association, on behalf of its 10,500 members, has petitioned the Supreme Court of Florida for "Modification of proposed Amendment of the Code of Professional Responsibility." The FMA supports the apparent contention of the Florida Bar that changes to Disciplinary Rules 2-106 and 2-107 are in the interests of the Court, the profession and the public but feels the proposed amendment with respect to the percentage of contingent fees above which the courts should regard as excessive is **much too high** to bring about the improvements which are sought in this proceeding. Further, it is their feeling that the proposed schedule of fees are of such a level as to attract or invite some attorneys to continue to file unmeritorious claims, particularly when no liability exists and the expense of defending such actions will reflect itself in the increasing insurance rates of malpractice insurance.

The Academy of Florida Trial Lawyers has stated that "in a limited number of circumstances, there have been abuses of the contingent fee system by a limited number of lawyers."

The Court's attention was then directed to the schedule of contingent fees adopted by the Supreme Court of New Jersey.

1) 50% on the first $1,000 recovered
2) 40% on the next $2,000 recovered
3) 33⅓% on the next $47,000 recovered
4) 25% on the next $50,000 recovered
5) 10% on any amount recovered over $100,000
6) 25% on the first $50,000 if the recovery is settled without trial for an infant or incompetent.

Further, the New Jersey rules, as in the proposed Florida rules, provide that an attorney can obtain a court hearing to request a higher fee if the settlement results in an inadequate fee.

The contingency fee, in conjunction with an insurance system that is willing to pay several thousands of dollars to an attorney and his client for an agreement **not to sue**, encourages some lawyers to take cases with little or no merit so that they can get some settlement from an insurance carrier. It is further well known that under the contingency fee system, estimates of 17 to 35 cents out of every malpractice premium dollar is usually all that goes to the injured party.

The system also does not necessarily force a lawyer to bear the expenses of a case in which he gets no settlement. At times, the physician reviewing medical records for a lawyer has been paid by the client rather than the attorney when the case has not been taken to court.

Dr. Lehman is a member of the Florida House of Representatives, District 97.

General Damages (pain and suffering) are an integral part of our civil liability system. Many medical malpractice cases are quite complicated and some judges, attorneys and juries frequently do not understand the medical terminology used in the presentation of the case. Most cases are based on unexpected results and not on negligence or true liability.

In 1973, a 21-man panel completed a study for the Department of Health, Education and Welfare in Washington. The Commission found "that patient injuries, real or **imagined,** are prime factors in the malpractice problem." They further reported that of the 12,000 malpractice claims occurring in 1970, 51% fell into the category of "temporary injury," in 21% the patient's injury was considered "insignificant," and in 12% the patient had suffered "no physical injury at all."

It has been further pointed out in Massachusetts, Michigan and now in Florida, that the incidence of malpractice claims rose between 40% and 50% following the passage of "Automobile No Fault Legislation."

The United States of America is the only nation in the world with an entrenched contingency fee system and we are **the** nation with a serious medical liability crisis. In Canada, standards of medical care are the same as ours, but the contingency fee is not a major factor. The premium for Canadian doctors is approximately $200 a year. American physicians pay 50 times that amount. Does that indicate that Canadian doctors are 50 times more competent than American doctors?

In conclusion, it is my opinion that trial attorneys should be working closely with the medical and insurance professions in an attempt to solve this problem. Perhaps this is the time for serious consideration to be given to the realistic control of contingency fees in Florida as has already been done in New Jersey. HB 2395 is submitted as a possible solution.

▶ Dr. Lehman, 2740 Hollywood Boulevard, Hollywood 33020

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The National Health Planning and Research Development Act PL 93-641

Luis M. Perez, M.D.

Most physicians have been somewhat aware of developments within the U. S. Department of Health, Education, and Welfare which have reached crescendo proportions in building a health care empire. The Department's efforts did not begin in 1946 with passage of the Hill-Burton Act. It only opened the way into a new and larger field unknown to the bureaucrats. The comprehension literally "blew their minds" to the unlimited potentials which control of the health delivery system would mean.

The initial entry into the larger field occurred in 1965 and 1966 when, after years of consideration and demagogery, Medicare and Medicaid became effective providing extensive federal involvement and participation in health insurance. In 1965 enactment of the Heart Disease, Cancer and Stroke Act amendment and in 1966 the Comprehensive Health Planning and Public Health Service Amendment created first the Regional Medical Program (RMP) and then the Comprehensive Health Planning Program (CHP).

A major addition to the Medicare act in 1972 added a mandate for review of all capital expenditures and services which received Medicare and Medicaid reimbursement, and legislation was passed establishing the ill-conceived Professional Standards Review Organization (PSRO) with regulatory authority.

The new legislation, PL 93-641, known as the National Health Planning and Research Development Act of 1974, was signed by President Ford on January 4, 1975. It encompassed, summarized and strongly reinforced the previous legislation.

What Is PL 93-641?

PL 93-641 is a complicated piece of legislation, very specific in some aspects, very vague in others; at best it is deceiving; at worst, malicious. Beginning with its designation, it is true that planning and development are emphasized. It is also true that in the regulations as well as the law itself, decision-making power is included.

The terms "planning and recommending," "evaluating and commenting" and similar ones included in previous laws have been changed to "planning and deciding" and "evaluation and deciding" with no clarification of how the decision may be appealed or reversed. "Price contention," "avoidance of duplication," and "orderly organization and development" are phrases most often used by HEW representatives and the state bureaucracy regarding the law.

The new and broad description of the term "provider" deserves some comment because of its hidden political implications. A provider is not only the person directly giving health services but encompasses all members of boards of charitable organizations related in any way to medicine, such as the Heart Association, Muscular Dystrophy, and Crippled Children, and to members of boards of health insurance organizations. Blue Cross and Blue Shield board members represent the consumers and are considered providers.

This may have a dual advantage to HEW. First, it diminishes the number of physicians on the boards of health system agencies (only 40% of the members can be providers) and minimizes the possible input by organized medicine in the decision-making process. Second, while regulating the functions of all voluntary paramedical organizations on the basis of fractionated and uncoordinated efforts, the possibilities that these functions can be used for fund raising, dedicated to matching funds called for in the Act, will be a big burst to bureaucratic plans for absolute control of research funds. These funds, also will provide for further planning to make the empire grow to unthinkable proportions.

PSRO and PL 93-641

As part of National Health Priorities, number 6 is mentioned as "promotion of activities to achieve improvement in the quality of health services, including needs identified by the review activities of the Professional Standards Review Organizations under Part B of the Title II of the Social Security Act." Number

Dr. Perez participated in the training seminar on PL 93-641 in Palm Beach, October 16-19, 1975.

3 is HMOs, and number 4 physician assistants, especially nurse clinicians, whatever this classification is. Authority of the PSRO organized and ruled by the RSO supersedes any other system of review (referring to medical societies).

Concerning the nurse clinician concept, no one has a definition of such an entity and surveys among nurses failed to obtain a clearcut difference in a nurse clinician, nurse practitioner or a specialized nurse. No doubt the definition will not be too late coming from HEW as well as regulations to protect the so-called "minority group in the health delivery system," physician assistant and nurse practitioner.

Conclusion

If the steps are followed through the history of federal intervention in the health delivery system from inception of the Hill-Burton Act, eye-opener to the bureaucrats in this new field, it is easy to understand the fast pace at which the whole plan is moving to its final result—the all-powerful National Health Organization with absolute control over the whole system.

The next step is control, and possible take-over, of all physical facilities, hospitals and nursing homes, and at the same time, in the name of effectiveness and coordination, disruption of all voluntary paramedical agencies with research money capabilities.

Following, and as a logical consequence, is control of the institutional practice of medicine, curtailing the private practitioner in the name of utilization and price control while undermining his practice with the opening of hospital-based outpatient departments. These would not be for the purpose of teaching but for actually establishing multispecialty groups under direct control of hospital administrators and supervised by the National Health Organization's local representatives. To this the law specifically gives priority.

Finally, when the private practitioner weakens from a half-empty practice because of "free" outpatient clinics, comes the last blow. It is delivered in the name of price regulation and contention, limitations in prescribing capabilities (already on their way in Medicaid patients) and PSRO applied to private offices.

Perhaps the picture is gloomy; my political acuity is not great. I, too, have been working, submerged in the profession and worrying about patients more than about politics, but sad and painful previous experiences make me feel the worst in view of similar circumstances. Maybe it is too late to change the course of events, but the dreadful consequences to the country and to the health services justify an effort toward modification. At the risk of being considered naive, at best, I include these general recommendations.

Apart from the legal battle which requires first class advice to attain, at least, fundamental changes in the regulations, the Florida Medical Association should disseminate copies of this law, thus making every physician aware of its dangers.

An intensive, constant public relations program should be developed to make the general public aware of the expenditure of tax monies to achieve the intents of this law.

Articulate physicians committed to the principles of private practice and free enterprise as a fundamental basis for personal freedom should be placed within the boards of local and state organizations to influence as much as possible the decision-making and conclusions arrived at by these organizations.

Physicians with sons and daughters in medical schools or who will be in the future or young, dynamic physicians should be given priority to participate in these boards. They should be well informed about the aims of the Florida Medical Association and the principles of the law.

The public relations programs can be derived from achievements within the medical profession if members of local medical societies can be stirred out of their complacency and react with vigor and determination.

The bicentennial celebration can be utilized, if well-developed programs are presented, to cause people to realize the great advances, facilities and efficient medical care they receive. Physicians should be ready to recognize that improvements must be achieved in the field of medical care and public health, but each must show that he has been actively involved in the efforts.

The state can be divided into regions and speakers with knowledge of the problems, able to make consequences of the law clear to other physicians, can visit every medical society in the area, challenging members to become active in defense of our principles and to take part in local activities in this respect. These speakers can be followed with visits by speakers from neighboring areas to show variety of expression and keep alive the quasi-rebellion among our peers.

More ideas come to mind—letters to the editors of newspapers, articles that can be published by magazines and newspapers with very little prodding if well written, participation in forum programs on television—so many events that are open for the

asking if physicians make the right contacts at the right time.

These suggestions are not new, but perhaps they may contribute to the preservation of principles that were taken from me at one time, in part because of my own complacency and lack of awareness and disbelief that it could happen.

▶ Dr. Perez, P.O. Box 1300, Sanford 32771.

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Jack A. MacCris, M.D.

ORGANIZATION

Jack Achilles MaCris

Jack Achilles MaCris, M.D., our new President of the Florida Medical Association, comes to us from St. Petersburg where he has practiced his specialty of General and Peripheral Vascular Surgery for twenty years. He was born in Highland Park, Michigan, and received his medical degree from the University of Michigan after serving as a Line Officer aboard a heavy cruiser during World War II. He served his Residency and Post-Graduate study period at the University of Michigan Medical School before entering private practice.

Jack's dedication to his community has been diversified and notable. He has served as Director of the Kiwanis Club, Vice President of the St. Petersburg Art Museum, a member of the Board of Governors of the St. Petersburg Chamber of Commerce, and a former Executive Committee member of the Pasadena Community Church. He has been President of the Pinellas Medical Society, serving in numerous capacities for that organization, and has served as Chief of Staff at St. Anthony's Hospital.

Although a transplanted Michigander, Jack has become a devotee to the Florida sun and sand. He is an avid fisherman, but his chief avocation is golf. This he attacks with the same enthusiasm and vigor that he exemplifies in his professional activities. To his golfing colleagues he is affectionately known as "the gorilla." Whether this endearing term is meant to describe his great power off the tee, or for his propensity for wandering the forests adjacent to the fairways, is not known.

Jack is a founder and former Vice President of the Florida Physician's Association, a founding member and Past President of the Florida Association of General Surgeons, Past President of the Florida Chapter of the American College of Surgeons, a former member of the Board of Directors of Blue Shield of Florida, and a former Council Member of the Frederick A. Coller Surgical Society.

His devotion to, and leadership in, the Florida Medical Association stands as a record of dedication to organized medicine. He has served on the Executive Committee, Board of Governors, the Committee of Seventeen, and the Council on Medical Economics. During the past year as President-Elect of the FMA, he has made considerable contributions along with Doctor Astler and the Board of Governors in helping to solve the many problems that confront our Association, and medicine in general.

To those of us who know him intimately, there is derived considerable satisfaction in knowing that our new President is a man not only of great ability, but a man whose courage is unwavering, whose ethical standards are never compromised, and a man who will speak as an honest spokesman in the defense of our medical freedom, which we all cherish.

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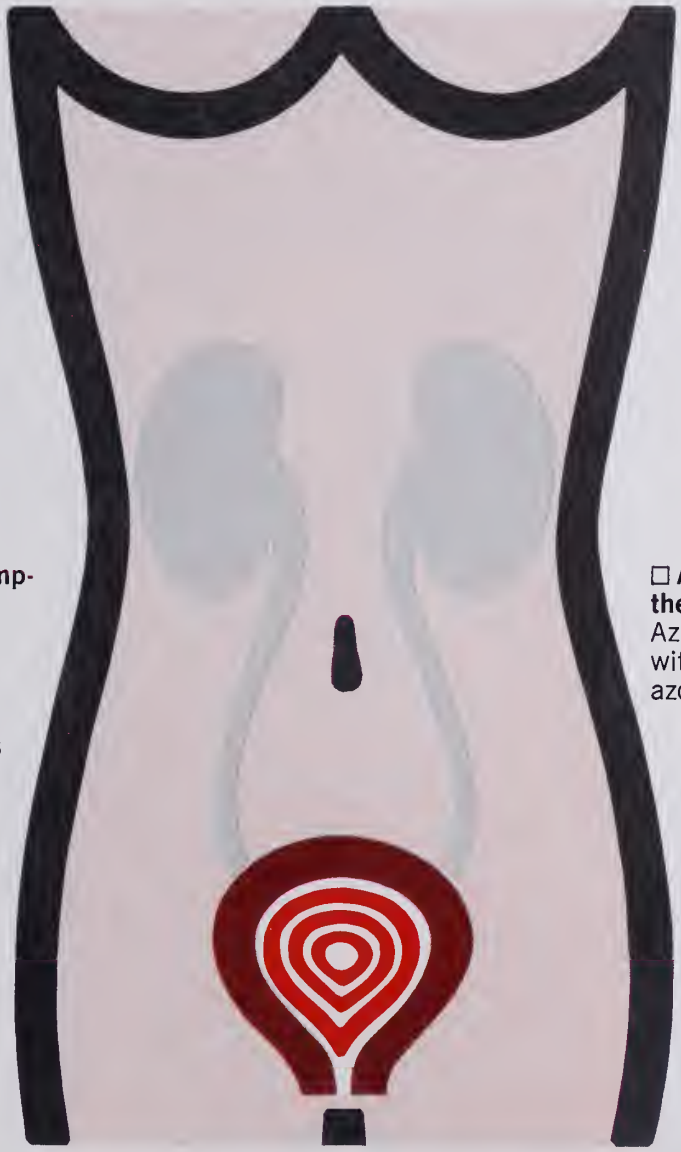
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Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

*Warning

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



*Trademark

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Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
□ Can relieve nausea and vomiting often associated with vertigo.*
□ Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.
□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

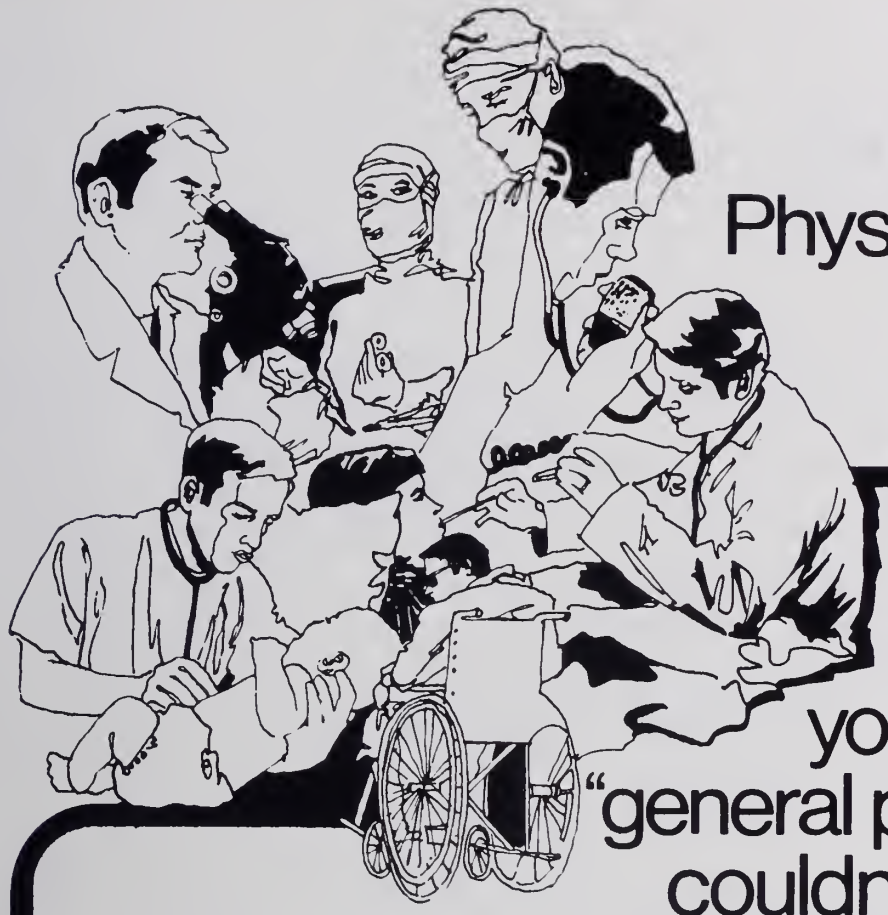
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



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Air Force Medicine

EDITORIAL

On the Insanity Defense

First and foremost, it should be made clear at the outset that "insanity" is not a medical term. It is a legal term, a legal concept, that consists of two factors: some form of mental illness, and a resulting incapacity. In the insanity test used in the State of Florida (McNaghten), it is the incapacity that is the critical excusing condition, not the mental illness. There was another test no longer in use (Durham) in which certain forms of mental illness were equated with incapacity.

One of the prerequisites is that at the time of the commission of the crime, the accused did not have the mental state, referred to in law as "mens rea," or "guilty mind." If, because of mental impairment, defect, or disease of the mind, the person acted in ignorance of the facts, this person should not be considered blameworthy. It follows, then, that if he is not blameworthy, it would be unjust and unfair to convict him of a crime.

For the past one hundred years, most American jurisdictions have followed the so-called McNaghten Rule. This rule was established in an English case in 1843 involving the trial of McNaghten on a murder charge. McNaghten was found not guilty by reason of insanity. The Court held that an act performed by an idiot, an imbecile, or insane person, is not a crime if—at the time committing such an act—the accused was laboring under such a state of mental illness or mental defect as to be incapable of understanding the nature and quality of the act, or to know that the act was wrong. Simply stated, the defendant was judged on the basis of his ability to know the difference between right and wrong. However, the vagueness of the words "quality," "know" and "wrong" have led to considerable controversy regarding the correctness of the McNaghten Rule as the measure of criminal responsibility.

The McNaghten Rule has been modified in some states by the rule of "irresistible impulse." In such jurisdictions, a person may know that an act is wrong, but if he is laboring under such a state of mind that prevents him from controlling his acts in conformity with his knowledge, he may claim insanity as a defense. This test, which is closely linked with the concept of "temporary insanity," does not explicitly define motivation, nor does it resolve the problem of how to assess criminal responsibility.

Psychiatrists and many experts in law believe that determining the "motivation" of an act is intrinsic to determining the responsibility for the act. A paranoid, delusional, or hallucinatory person may "know" that murder is legally or morally wrong, nevertheless, he may still be driven to kill someone in response to his aberrated thinking, or to an hallucinated command. Should such a person be criminally responsible?

Another test of insanity used in some federal and state jurisdictions is the so-called A. L. I. (American Law Institute) which holds that the accused is excused on the grounds that because of mental illness, he lacks substantial capacity to either "appreciate" the wrongfulness of his conduct, or to conform his conduct to the requirements of the law. Simply stated, the accused says, "I didn't know what I was doing," and, "I couldn't help it." The first part of this is strictly McNaghten, with the second part being A. L. I.

Lately, Dr. Menninger and many others—including the writer—advocate the abandonment of "mens rea" as an element of crime. The defendant's mental condition would not have any bearing in determining whether he had committed the crime or not, or what the motivation was, etc. But once the individual is adjudged guilty, his mental condition

would have a bearing in aiding what the disposition might be (hospitalization, probation, jail, etc.).

As can be readily seen, the role of psychiatry in criminal law is still in the making; however, the direction is clear. Society is beginning to recognize that the person with mental illness must be given every opportunity for treatment, even when his behavior comes within the legal definition of criminality.

Arturo G. Gonzalez, M.D.
Tampa

Reprinted from The Bulletin, Hillsborough County Medical Association, April 1976.

Editorial Comment

Doctor Gonzalez makes a reasonable plea for treatment of the mentally disturbed person even when overt behavior involves criminal acts. He has also summarized the insanity matter succinctly.

My experience with juries spans more than twenty-five years and I believe the juries often do the right thing though perhaps, at times, for the wrong reason.

Two cases come to mind. A father had two teenaged daughters being provided drugs by a moderately notorious pusher. The young girls were caught with drugs and the family expected them to be sentenced to confinement. The father went to the pusher's house and shot him with a shotgun at close range. The father was found sane by two psychiatrists and readily admitted his sanity in the courtroom. The jury, however, found him not guilty by reason of temporary insanity. In other words, they voted as parents rather than as psychiatrically sensitive jurors. Only the youngsters of the community saw fit to criticize the jury's views.

A very psychotic construction worker with a lengthy history of severely paranoid thinking and behavior shot and killed a union representative he believed the cause of his unemployment. He then attempted to kill himself. Two psychiatrists confirmed his overt psychosis. After eighteen months in the State Hospital and psychopharmaceutical remission of symptoms a jury found him, "Not psychotic" at the time of the shooting and guilty of 2nd degree murder which led to a twenty year sentence. The hospital report had warned of the risk of recurrence if medication was discontinued. The jury seemed to be attempting to answer society's problem of, "What do we do with a homicidal paranoid who has killed when psychotic and might kill again?" Their answer seemed to be that he could be watched adequately in the state prison and be provided needed medication.

All physicians dealing with this problem of mental illness and crime are aware that some persons may be clearly psychotic yet know right from wrong and that the act they are committing is wrong. Though clinically psychotic they are responsible for their actions. If physicians who testify in criminal cases keep this clearly in mind there will be less cause for public criticism of psychiatrists protecting criminals.

If psychiatrists enter the picture only after the guilt or innocence has been determined, as Doctor Gonzalez suggests, would we be hanging McNaghten at last, failing to help the courts, or denying the accused the help that McNaghten has given for over a century, or? — Philip B. Phillips, M.D., Pensacola

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Commentary

Medical Director's Role in the Skilled Nursing Facility

Many skilled, long-term patient care facilities retain a physician for consultation upon emergencies and in general medical policies. Regularly scheduled medical supervision generally has been lacking in most of these institutions. Too often the physician's role is not definitely determined and consequently the administrator and nursing director as well as the physician have difficulty maintaining their respective professional relationships. When the problems are realized and admitted and there is a desire for satisfactory solution, the physician's role may evolve into that of medical director. In this event, his duties will be similar to those of the organized medical staff; that is, to assure quality patient care. Additionally, he will be responsible for coordinating, monitoring and supervising the care.

The medical director's duties and responsibilities should be spelled out in a formal agreement and the amount of time he devotes to various activities agreed upon. But he should not go into the nursing home swinging his mandate and proclaiming that he is captain of the team. The nursing director and administrator may have been there a long time and it will take adjustment on their part to accept his role. If he stresses that his principal aim is the best possible care for patients, soon they will be happy to have him around.

He should spend a scheduled number of hours each week sharing his knowledge with the nursing director, administrator and other staff members. Where there has been no previous medical direction, he will be a definite asset. His presence will help to create a more therapeutic environment and provide considerable encouragement and support to patients, relatives and staff. In a short time all of them will become aware that he has assumed responsibility for overall coordination of medical care which will help insure the adequacy and appropriateness of medical services.

The medical director should be a clinician whose primary focus is upon long-term patient care, not federal regulations and Medicare definitions. He should be a teacher, first of himself because his previous training will fail to enlighten the circumstances he presently faces; then of the staff members.

The pyramid of skills necessary to the care he desires to have provided in the nursing home is only as good as the broader foundation. He may be an excellent clinician and diagnostician but his abilities will be less effective if the aides fail to provide the best possible care. In the hospital his relationship was with his colleagues but in the long-term care facility he must relate to the semiskilled staff and to those with less training. Communication is not the art which had been developed in the previous environment but it is absolutely necessary.

To assure effective functioning of the interdisciplinary approach, he should be involved in regular staff meetings. There should be a similarity in his relationships with all professional staff members.

The medical director assists and guides the nursing director; they work together, thus her responsibilities are made easier by his advice and counsel. He participates in developing the policy which governs medical, nursing and related services and is familiar with laws and regulations regarding physicians assistants and geriatric nurse practitioners.

His duties encompass advice to supervisors of the house staff, involvement in maintenance concerns, team building, and education of the staff in goals, infection control, and health. These duties in specific functional areas, shared with the administrator and nursing director, should be spelled out in the formal agreement with the nursing home.

This is a summary of discussions at the seminar on "The Role of the Medical Director in the Skilled Nursing Facility" held in Tampa, January 10-11, 1976. It was presented by the Florida Medical Association in cooperation with the American Medical Association and Florida Academy of Family Practice.

The medical director may express some apprehension about getting along with attending physicians and committees in the facility. This appears to have no foundation. There should be no problem to obtain the participation of attending physicians provided he develops an effective liaison with the county medical society. This area requires considerable study, diplomacy and education, however. Assistance of the medical society and hospital association should be solicited in the solution to problems.

The medical director's challenge is to assure that the nursing home is operated to benefit patients and to create an awareness among physicians that the care provided is a modicum of the community's total health care.

E. Charlton Prather, M.D.
Tallahassee

Dr. Prather is Staff Director of the Florida Health Program Office, Tallahassee and an Associate Editor of the Journal of the Florida Medical Association.

Liability Insurance Coverage for State Contract Physicians

The physician who treats patients on a contract basis with the State of Florida should have personal professional liability insurance as protection against judgments exceeding the $50,000/$100,000 limit established in Section 768.28, Florida Statutes. David St. John of Tallahassee, general counsel for the state's Department of Health and Rehabilitative Services, advises that the physician probably would not be classified as an officer, employee or agent but rather as an independent contractor. He defines an independent contractor as a "person who performs contract work under circumstances involving substantial independence as to how to accomplish the contract duty."

The officer, employee or agent of the state are not held personally liable for "injuries suffered as a result of any act or omission occurring in the scope of his employment unless such person acts in bad faith or with malicious purpose." The state is interposed as the defendant in the case and, thus, the plaintiff is provided with an alternative remedy to suit against the employee.

In a medical practice where there is substantial supervisory control over the physician's activities, he would be within the definition of an agent. Thus, he is protected and the state would be substituted as defendant in any case brought against him for injuries arising out of the performance or nonperformance of his duties.

In cases where the contract physician has substantial property, Mr. St. John states that attorneys for the plaintiff attempt to have the court hold that the physician is an independent contractor, not an officer, employee or agent. This way the limits of liability established in Section 768.28(5), which are $50,000/$100,000, are defeated. There is, therefore, substantial danger to a contract physician with substantial means who relies solely upon protection afforded to agents or employees of the state.

Summary of the 1974 Florida Maternal Mortality Report

The Maternal Mortality Committee, prior to June 1974, was under jurisdiction of the Florida Medical Association. Due to reduction in the number of committees, the Association elected to turn over all records to the Bureau of Maternal Health and Family Planning of the Health Program Office in the Department of Health and Rehabilitative Services so that the Bureau, by common agreement, would continue the study of maternal deaths in the state and prepare reports as indicated for educational purposes. This report is an outgrowth of such a goal. At the same time, the Association appointed these physicians to serve as advisors to the Bureau as needed: Samuel L. Renfroe, M.D., Ocala (Obstetrics and Gynecology), Chairman; Frank C. Bone, M.D., Orlando (Gastroenterology); Richard Boothby, M.D., Jacksonville (Pediatrics); Clifford R. Guy, M.D., Jacksonville (Cardiovascular Diseases); John Kruse, M.D., Jacksonville (Anesthesiology); Charles L. Lippoldt, M.D., Orlando (Anesthesiology); and Laudie E. McHenry, M.D., Melbourne (Pathology). Representing the Bureau of Maternal Health are Archibald F. Caraway, M.D., Sarasota (Obstetrics and Gynecology), and Harold P. Auslander, M.D., Jacksonville (Obstetrics and Gynecology).

Methods

Each maternal death is studied and classified as recommended by "A Guide for Maternal Death is Studied," which was revised in 1964 by the Committee on Maternal and Child Care of the Council on Medical Services of the American Medical Association. The Public Health Statistics Section, Bureau of Vital Statistics, forwards maternal death certificates to the Bureau of Maternal Health and Family Planning which sends questionnaires to the physicians involved. An effort is made to obtain all other information from the hospital records and autopsy reports. Each case is then studied and classified by the Bureau and questionable cases brought to the attention of the advisory group.

The definition of maternal death is "the death of any woman dying of any cause whatsoever while pregnant or within 30 days of the termination of the pregnancy, irrespective of the duration of the pregnancy at the time of termination or the method by which it was terminated."

In 1974 there were 110,404 live births and 15 maternal deaths, a rate of 1.4 per 10,000 live births (Tables 1, 2).

Table 1.—Florida Maternal Mortality 1974 (Primary Cause of Death).

Cardiomyopathy	3/15
Septicemia	3/15
Disseminated Intravascular Coagulopathy	3/15
Pulmonary Embolism	2/15
Hemorrhage	2/15
Sickle Cell Anemia	1/15
Abruptio Placentae	1/15

Table 2.—Maternal Mortality Rate per 10,000 Live Births.

	Florida	United States
1950	12.9	8.3
1960	5.0	3.7
1970	3.0	2.2
1974	1.4	2.1

Definitions

Maternal deaths are divided into three categories:

1. A Direct Obstetric Cause. This is a death resulting from complications of pregnancy itself, from intervention elected or required by the pregnancy, or resulting from the chain of events initiated by the complication or the intervention.

2. An indirect Obstetric Cause. A death resulting from disease before or developing during pregnancy (not a direct effect of the pregnancy) which was obviously aggravated by the physiological effects of the pregnancy and caused the death.

3. A Nonrelated Cause of Death. A death occurring during pregnancy or within 90 days of its termination from causes not related to the pregnancy nor to its complication or management.

Recommendations

1. On the death certificate, a space should be provided that states the patient was pregnant or pregnant within 90 days of death. This is to be communicated to the Bureau of Vital Statistics.

2. With the problem of stillborn statistics in elective abortions past 20 weeks, there should be some identification that this was an abortion, as opposed to a stillborn.

3. A brief summary as a "report" should be submitted to the Journal of the Florida Medical Association.

Critique of the 1974 Maternal Mortality Report

William N. Spellacy, M.D.

Maternal mortality committees usually have the charge to review all maternal deaths, identify correctable causes, educate health care personnel, and monitor and improve pregnancy care. The newly constituted committee for Florida has presented its first report on deaths in 1974. The members are to be congratulated. It is, however, obvious that such a committee cannot adequately function unless it has access to all the records within the state. This most probably is the single most vulnerable point of the current report. There presently is no way that the committee can be assured that all maternal mortality cases have been reported for review. As a consequence, there is no way from these data that rates, rate changes, or rate comparisons can be discussed. Any failure to report cases to the committee will obviously appear factitiously to a committee as an improvement in health care. The committee has recognized this serious weakness in its data and has requested that Florida follow the lead of many other states by putting a box on the death certificate whereby the physician must designate specifically whether the death represents a maternal mortality. Hopefully, the wisdom of this will be understood by appropriate authorities and will be enacted.

There are important points which can be gleaned from the present report, including:

1. 60% of maternal deaths in 1974 were preventable.
2. The classic triad of causes of maternal deaths still prevails, namely, hemorrhage- infection- toxemia.
3. The risk of deaths for nonwhite women is 4.5 x increased.
4. Ectopic pregnancy is a serious and often fatal disease.

Finally, it is recommended that in the future the committee follow the definition of maternal mortality as set down by the World Health Organization and the American College of Obstetricians and Gynecologists, that is, to include only 42 days postpartum. In this way the data can be compared to other regions of the United States.

Again, committee members should be commended on this important activity. They should also be aided in their work by appropriately changing the death certificate. Quality perinatal care is demanded by society and we must maintain a surveillance system to guarantee that it exists.

Dr. Spellacy is Professor and Chairman, Department of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville.

Everyone is a prisoner of his own experiences. No one can eliminate prejudices—just recognize them.

Edward R. Murrow

12-hour claims
are nothing new.

12-hour relief is.



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Novafed® A Capsules

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Controlled-Release Decongestant Plus Antihistamine

It goes the distance.





Clinical studies confirm full 12-hour effectiveness.

For years, patients have heard of drugs providing long-lasting relief. But after six or eight hours, they often run out of relief. And it's too soon to take the next dose.

Now, with Novafed A, Dow introduces a prescription capsule with 12-hour effectiveness in relieving allergy and hay fever symptoms. Placebo-controlled clinical studies show that the high level of decongestant in Novafed A provides relief for as long as 12 hours. At the same time, its antihistamine relieves the patient's itchy eyes and runny nose *without* the excessive dryness of anticholinergic agents.

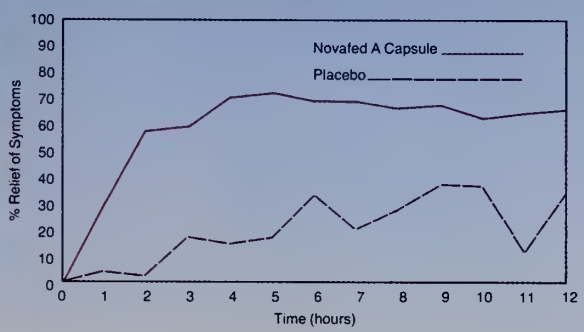
Prompt onset of effect is followed by full 12-hour relief.

(Please refer to the following page for bioavailability studies and prescribing information.)



Patients with severe pollen allergies were tested during hay fever season in a countryside environment and asked to rate severity of five different symptoms on a scale of 1 to 4.

Clinical Study: Degree of Relief from Itchy Eyes and Nose and Throat, Watery Eyes, Runny Nose*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

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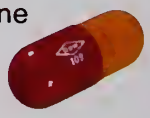
NEW

Novafed® A Capsules

Each capsule contains pseudoephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.



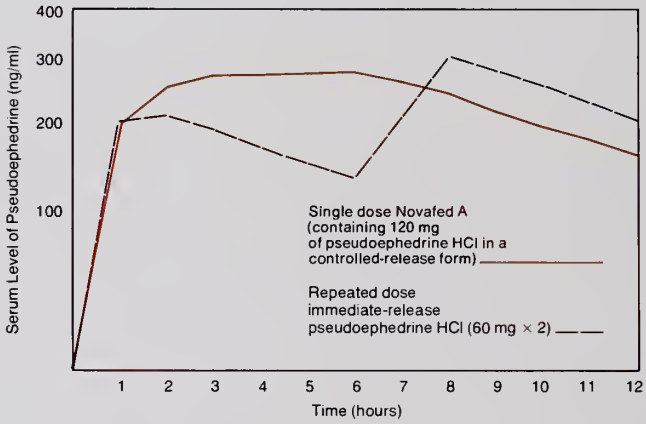
Prompt onset and sustained serum levels over 12 hours.

A bioavailability study confirmed that the sustained 12-hour action of Novafed A was comparable to that of immediate-release medication taken at 6-hour intervals.

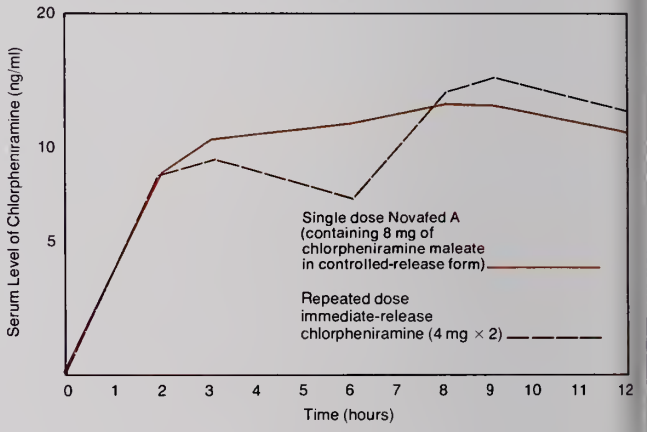
The chart at the left shows the serum levels of pseudoephedrine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 60 mg. pseudoephedrine hydrochloride in an immediate-release form. Serum levels of pseudoephedrine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

The chart at the right shows the serum levels of chlorpheniramine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 4 mg. chlorpheniramine maleate in an immediate-release form. Serum levels of chlorpheniramine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

Comparison of Mean Serum Levels of Pseudoephedrine Following Novafed A and an Immediate-Release Reference Formulation*



Comparison of Mean Serum Levels of Chlorpheniramine Following Novafed A and an Immediate-Release Reference Formulation*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DESCRIPTION: Each NOVAFED A capsule contains 120 mg. of pseudoephedrine hydrochloride and 8 mg. of chlorpheniramine maleate. The specially formulated pellets in each capsule are designed to provide continuous therapeutic effect for about 12 hours. Nearly one-half of the active ingredients is released soon after administration and the remainder is released slowly over the remaining time period.

ACTIONS: NOVAFEO A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

INDICATIONS: NOVAFEO A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Oecongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIONS: Symphathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFEO A controlled-release capsules should not be used in children less than 12 years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension or in patients with a history of bronchial asthma.

Oo not exceed recommended dosage.

Use in Pregnancy: The safety of pseudoephedrine for use during pregnancy has not been established.

Use In Elderly: The elderly (60 years and older) are more likely to have adverse reaction to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIDNS: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Oo not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: NOVAFED A is supplied in red and orange colored hard gelatin capsules, monogrammed with the Dow diamond followed by the number 109, in bottles of 100.

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Announce

"THE THIRD ANNUAL CARDIOVASCULAR SYMPOSIUM"

SEPTEMBER 9-10, 1976

THE GAINESVILLE HILTON INN — GAINESVILLE, FLORIDA

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

This symposium is designed to review and explore the diagnostic procedures and therapeutic modalities that are available for the detection and treatment of cardiovascular disease. A special evening session is devoted to the use and value of echocardiography. An outstanding faculty has been assembled for the symposium and the program should be of interest to all physicians taking care of patients with cardiac disease.

FACULTY

CHRISTIAN BARNARD, M.D.	MICHAEL DeBAKEY, M.D.	RENE FAVALORO, M.D.
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THOMAS B. FERGUSON, M.D.	JOSEPH W. LINHART, M.D.	SPENCER B. KING, III, M.D.

(Approval for credit for CE units has been requested from the AAFP, FMA, AACN and FNA.)

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Hotel, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton Inn direct, (904) 377-4000.

RESERVATION FEES: $150. — all physicians
50. — paramedical personnel (nurses, technicians, etc.)

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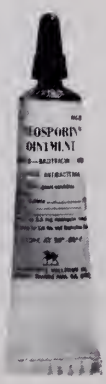
Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

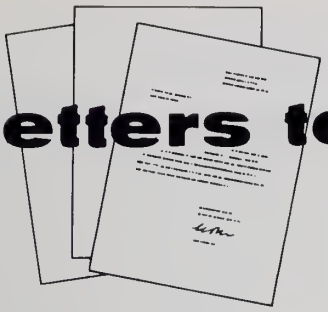
Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Letters to the Editor

To the Editor: Whenever a scientific journal includes material which confuses rather than clarifies, exalts a nonscientific approach and seems to support fringe practices, it is time to call attention to such. I am referring to the article entitled "Parapsychology and Medicine," by Edward Pedrero Jr., M.D., reprinted from the Bulletin of the Hillsborough County Medical Association of January 1976.[1] This article appeared in the February 1976 Journal of the Florida Medical Association under the heading Others Are Saying. That the article should appear in the same issue as the careful scientific appraisal of acupuncture by Jerome H. Modell, M.D., tends to detract from that clear and well documented effort.

In times of social stress and uncertainty, there has always been a trend toward mysticism. Physicians have not been free of this impulse.[2] If we are unaware of this we will allow repeated waste of scientific resources. Your journal is not alone in this as the recent publication of psychic Uri Geller's trickery appeared in Nature,[3] a well-known and usually scientific journal. The appeal of this sort of thing often sidetracks both energy and financial assets. With the gradual shrinking of federal and local support for medical research and care, this is a danger that should not go unmentioned.

Including the name of a private foundation in your journal lends a certain credibility to it. Many unsubstantiated claims were made in the article and we are told that parapsychology, para-normal healing, biofeedback, acupuncture, psychic diagnosis, bioenergetics, altered states of consciousness, mind-body interaction, Edgar Cayce readings and laying on of hands have been discussed. Combining such topics, some of which have been the legitimate study of psychologists and psychiatrists while others are clearly of a religious nature, some quackery and some in early experimental phase can serve only the purpose of attracting the curious and confusing the credulous. Biofeedback which grew out of experimental psychology, psychophysiology and learning theory seems particularly out of place. Claims for hypnosis and meditation are best ignored unless carefully documented and scientifically controlled.[4,5] The history of studies in clairvoyance diagnosis, parapsychic phenomena and ESP are replete with the exposure of trickery and charlatanism as well as quackery often leading to serious consequences for the duped.[6,7]

Nothing I have said should be construed as a negation of the positive manner in which native healers support scientific medicine or the urge to better understand the usefulness of nonspecific factors in the healing process. Nor am I opposed to religious, existential or philosophical search in our lives. While I expect a journal of your calibre to include material that is thought-provoking, I would hope in the future that such is consistent with the objectives of accuracy and clarity.

Sincerely,

Richard M. Steinbook, M.D.
Associate Professor of Psychiatry
University of Miami School of Medicine

References

1. Pedrero, Edward Jr.: Parapsychology and Medicine, J. Florida M.A. 63:114, 1976.
2. Milbourne, Christopher. Mediums, Mystics and the Occult, New York, Thomas Y. Crowell, 1975.
3. Hasted, J. B.; Bohm, D. J.; Bastin, E. W.; Regan, B. O., and Taylor, J. G.: The Paranormal, Nature 254:470-473, 1975
4. Benson, H.: The Relaxation Response, New York, William Morrow and Company, Inc., 1975.
5. Barber, T. X.; Spanos, N. P., and Chaves, J. F.: Hypnotism, New York, Pergamon Press. 1974.
6. Milbourne, Christopher: ESP, Seers and Psychics, New York, Thomas Y. Crowell, 1970.
7. Hansel, C. E. M.: ESP, A Scientific Evaluation, New York, Charles Scribner's Sons, 1966.

To the Editor: Thank you for the copy of Dr. Richard M. Steinbook's letter in which he objected to the reprinting of my article "Parapsychology and Medicine" in the Journal of the Florida Medical Association.

The article was written for Hillsborough County Medical Association's Bulletin in the Read and Reflect Column. The article was intended as informative and thought-provoking and a perspective of parapsychology.

I am not a mystic but a practicing family physician and there can not be any fringe benefits for me as I only use traditional proven methods in my practice. For many years I have written editorials and articles for several journals in the State of Florida.

I was quite amazed that Dr. Steinbook felt that reprinting the article would detract from Dr. Jerome H. Modell's excellent article on acupuncture. "Serves only to attract the curious and confuse the credulous." This I find difficult to accept. I am highly flattered. Accuracy and clarity? If one reads carefully, my article always states "it has been claimed, reported," etc. The accuracy of the mentioned parapsychology phenomenons is not claimed by the writer, as a matter of fact, I wrote "proof that a healing effect was a parapsychological phenomenon would demand that the patient's recovery occurred under conditions that excluded all influences other than the healers."

Nontraditional therapeutic modalities should not be ignored and we should read and reflect about them. The Journal of the Florida Medical Association, also a communication media for the members of the Florida Medical Association, should present in the appropriate sections of the journal controversial topics in medicine as other members write or talk about them.

I believe it would be interesting to print Dr. Steinbook's letter and this letter in the Letters to the Editor section for possible comments from other readers. How do FMA members feel about original or reproduced articles dealing with controversial medical topics? Perhaps sufficient reader response could be obtained by printing Dr. Steinbook's comments on my article.

Very truly yours,
Edward Pedrero Jr., M.D., Ph.D.
Tampa

One man with courage makes a majority.

Andrew Jackson

To the Editor: I am enclosing a copy of my analysis of HB 3223 and would appreciate it if you would print it. In addition, would you add a comment I made in the Committee hearing in response to some remarks from the President of the Florida Chiropractic Society and his insistence on the necessity of having laboratory reports, x-rays and being afforded access to the hospital facilities.

I replied, "Doctor, according to the statutes, you are not permitted to prescribe or administer to any person any medicine or drug or to perform any surgery or obstetrics. Therefore, if a patient consults you and you find that your manipulations do not relieve the symptoms, don't you think the proper procedure would be to refer the patient to a licensed physician for further work-up? It would serve no useful purpose for you to have other diagnostic x-rays and/or laboratory reports since you cannot interpret them and cannot treat the patient. This is a duplicative process that can only raise the costs of health care." I received no response.

Chapter 460.11 "Chiropractic"— Analysis of HB 3223

(1) For all purposes chiropractic is defined to be a noncombative principle and practice consisting of the science of adjustment, manipulation and treatment of the human body in which vertebral subluxations and other malpositioned articulations and structures that are interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs, and tissue cells of the body, thereby causing disease, are adjusted, manipulated or treated thus restoring the normal flow of nerve impulse which produce normal function and consequent health.

(2)(b) Chiropractic physicians are expressly prohibited from prescribing or administering to any person any medicine or drug or from performing any surgery or practicing obstetrics.

(2)(d) Chiropractic physicians shall have the privileges of services from the Division of Health Laboratories.

HB 3223 is an attempt to provide certain privileges to licensed Chiropractors that are quite unnecessary. Last year, the Legislature passed a bill which allowed a patient to have hospital x-ray and laboratory reports sent to his chiropractic physician.

Noting carefully the work that Chiropractors perform, it seems clear that these reports would be of little or no value to the proper performance of their profession. This new bill, giving them **access** to all diagnostic facilities by each hospital licensed under

Chapter 395, excluding surgical diagnostic procedures for the purpose of patient referral, is totally unnecessary.

Since the bill states that "nothing in this section requires a hospital to grant general staff privileges to a Chiropractor," it escapes me as to why the authors of this bill should legislate that hospitals give to licensed Chiropractors access to all patient diagnostic and therapeutic reports and data including personal inspection of such reports and data if requested.

I have known many Chiropractors who practice their profession through manipulation as outlined in the statute and who recognize that the requests made in this bill are totally unnecessary. It is, therefore, my opinion that this bill is not only unnecessary but, possibly, could lead some Chiropractors into going beyond manipulation and entering the field of diagnostic medicine for which they have not been trained. There is also a very distinct possibility that once a Chiropractor has obtained these reports and placed himself in the position of having to make a decision affecting the patient's health, a malpractice action might result.

David J. Lehman, M.D.
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*Present as 345.9 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. fenoprofen.

600091



James E. McGuigan, M.D. . . . Professor of Medicine and Chief of Gastroenterology at the University of Florida since 1969, has been promoted to Chairman of the Department of Medicine.

He succeeds Leighton E. Cluff, M.D., who left Florida earlier this year to become a vice president of the Robert Wood Johnson Foundation in Princeton, N. J.

Dr. McGuigan is the recipient of many different awards, including the prestigious Distinguished Achievement Award of the American Gastroenterological Association in 1974. Last year the graduating class of the University of Florida College of Medicine selected him for the Outstanding Clinical Teaching Award.

A native of Tacoma, Wash., Dr. McGuigan received his M.D. degree in 1956 at the St. Louis University School of Medicine. He completed residency and fellowship training in internal medicine and gastroenterology at the University of Washington in Seattle.



James E. McGuigan, M.D. New University of Florida Chief of Medicine.

Pirate Captain Billy Bowlegs XXI . . . alias **William W. Thompson, M.D.,** of Ft. Walton Beach, Chairman of FMA Judicial Council, is pictured in four-color splendor and appropriate costume in a brochure trumpeting this year's Billy Bowlegs Festival. Decked out in satiny, gold-embroidered regalia and clutching a sword authoritatively, Captain Billy peered out over the bounding main as he prepared to become plain ole Dr. Billy again at this year's festival in June.

Gov. Reubin O'D. Askew . . . was the principal speaker at the dedication of the $26 million University of South Florida Medical Center in Tampa on May 21.

The complex, begun in 1972 and constructed in two phases, includes educational and research facilities constructed to accommodate an entering class of 96 medical students, the College of Nursing, facilities for graduate students in medical sciences at the Ph.D. level, a medical library and an Ambulatory Care Center designed to handle 100,000 patient visits annually.

The College of Medicine admitted its first class in 1971 and graduated its first 23 physicians in December of 1974. Seventy-four new students will enter the three-year program on July 1.

The greater the obstacle the more glory in overcoming it.

Jean Moliere



Are they too old to swing?

EACH TESTAND-B TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg.
Methyltestosterone	1.25 mg.
L-lysine	100 mg.
Nicotinic Acid	12.5 mg.
Iron (from Ferrous Sulfate)	2.82 mg.
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg.
Ascorbic Acid	25.0 mg.
Folic Acid	0.1 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inositol	10 mg
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.

Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets.

TESTAND-B INJECTABLE: VIALS OF 10cc.

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Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Physician's Handbook by Marcus A. Krupp, M.D.; Norman J. Sweet, M.D.; Ernest Jawetz, M.D.; Edward G. Biglieri, M.D. and Robert L. Roe, M.D. 18th Ed. 754 Pages. Price $8.00. Lange Medical Publications, Los Altos, Calif., 1976.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.-O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

The New Way to Live With Diabetes by Brian Boylan and Charles Weller, M.D. 140 Pages. Price $2.50 (paperback). Doubleday & Company, Inc., New York, 1976.

Foreign Travel Immunization Guide by H. H. Neumann, M.D. 32 Pages. Price $2.50. To order: Send check to Box 611, New Haven, Connecticut 06503.

The Woman Alcoholic by Vera Lindbeck. 28 Pages. Price 35¢. New York, Public Affairs Pamphlets, 1975.

Focus on Care of the Elderly by Donald F. Phillips et al. 114 Pages. Price $4.75. Contemporary Publishing, Inc. Wakefield, Massachusetts, 1975.

Preparation for Parenthood Through Group Discussion by Aline B. Auerbach. 57 pages. Available on request from Education Services, Patient Care Division, Johnson & Johnson, New Brunswick, N. J. 08903.

This book by a parent group consultant is subtitled, "A Guide For Nurse-Leader of Expectant-Parent Classes". This guide includes chapters on organization of expectant parent discussion groups, basic requirements for leadership, as well as techniques of group discussion and suggested curriculum. It includes a bibliography for suggested reading.

Blood: The River of Life by Donald R. Avoy, M.D. 76 pages. Price .75. Available from: American Red Cross Blood Program, National Headquarters, Washington, D.C. 20006.

This small book, complete with glossary should prove useful to laboratory technicians, nursing and allied medical personnel. This booklet includes function of the blood components as well as blood diseases. A brief section covers the Red Cross blood program.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus,** volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publications should be designated "For Publication."



Others Are Saying

The Waiting Game

For want of something better to do, I recently underwent some cutting and sewing at one of the local hospitals. I cannot speak highly enough of the care I received from my surgeon, the radiologists, the nursing staff, and the dietetic service. In truth, I was treated in a princely fashion, possibly because I AM a prince who was stolen in infancy from the family castle by some gypsies and left at the doorstep of those fine people who raised me as their own. This is conjecture on my part and cannot be proven because the castle burned down when a cow kicked over a lamp. But that's another story . . .

There was one aspect of my hospital stay that perhaps warrants some comment. For those who have not been hospitalized, a trip to the x-ray department may be one of life's less enthralling experiences. Usually, each patient has at least a chest x-ray which requires a visit to the radiologist's lair. If the film is to be taken in the morning, the patient is wakened at 0430 to put on the gown that is the sine qua non for the trip. It does not matter if the x-ray is to be taken at noon. You will be given this Dior creation (that's not Christian Dior—that's Sam Dior who has a little tent making outfit down on Market St.) at dawn's early light.

Although you may consider yourself in such splendid physical condition that you could participate in the Super-Star competition, it is de rigeur that you travel to x-ray in a wheelchair. The hospital administrator maintains this is to lessen the risk of injury and resulting suits against the hospital. The real reason is to relegate you to the status of a patient. That puts one down on the lowest tier in the hierarchy of hospital inhabitants. The cheerful young man or lady who pushes you to the department will deposit you in the corridor in Radiology with the other wheelchair riders. Your driver then leaves for a two week vacation at a rock festival in upper New York state.

The required x-ray will be taken with dispatch. You will then be returned to the corridor (sometimes known as the Valley of the Lost Souls) to await the appearance of a courier to take you back to your room. If this was a routine preoperative film, time will pass swiftly, particularly if you had the foresight to bring a copy of "War and Peace" with you. You will have finished no more than half the book before someone comes to roll you back to your room.

The main problem arises when the patient is acutely ill or aged. Under these circumstances, time may be distorted and a few minutes may seem like a few hours while one waits in the corridor for a good Samaritan to return you to your bed. During my recent hospitalization, I had to have an emergency GI series. I was brought to the department where the study was carried out promptly and with great skill resulting in the immediate diagnosis of my problem. However, I was then wheeled out into the passageway on my litter and left there with my IV dripping and feeling in general like the devil. As the time passed (probably not an inordinately long time although it seemed like hours to me), I considered getting down from my stretcher and lurching through the halls like some bedraggled Statue of Liberty holding my IV bottle high in my right hand while I steadied myself against the wall with my left. Meanwhile, my bare little bum bum would have been exposed to all onlookers through the opening in that infernal gown. I don't know whether it was weakness or the knowledge of how absurd I would look that stopped me, but I remained where I was. Eventually, I was returned to my room.

I hope my radiological friends (to whom I owe so much) will not be offended by my slight exaggerations. In talks with members of the nursing service, this stay of varying lengths in limbo has occasioned much discussion among patients. It is a difficult problem because of the shortage of personnel on the one hand and the hospital's responsibility for any injuries that might occur to unattended patients on the other. Perhaps bringing the problem forward will be of some help in directing efforts to ameliorate it.

Richard T. Donelan, M.D.
Jacksonville

Reprinted from the Editorials—Letters—Viewpoints section of Jacksonville Medicine, April 1976.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

JUNE

Sixth Annual Radiation Therapy Clinical Research Seminar, June 3-5, Shands Teaching Hospital, Gainesville**

Sexual Dysfunction, June 5, Holiday Inn, Longboat Key. For information: Allen R. Sklerov, M.D., 525 3rd St., E., Bradenton 33505

Family Planning Seminar, June 5, Broward County Health Department, Fort Lauderdale. For information: P.B. Keitlen, M.D., Box 210, Jacksonville 32201

1976 Clinical Conference on Pre-Hospital Emergency Care, June 12-14, Orlando Hyatt House, Kissimmee. For information: ACEP, 1919 Beachway, Suite 5-C, Jacksonville 32207

Florida Suncoast Pediatric Conference, June 14-16, Sheraton Sand-Key, Clearwater*

Hematology for the Practicing Physician, June 18-19, Holiday Inn, Tampa. For information: Frank B. Lane, M.D., One Davis Blvd., Tampa 33606.

10th Annual Workshop in Electrocardiography, June 21-26, Sheraton Sand-Key Hotel, Clearwater Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

Florida Academy of Family Physicians Assembly, June 23-27, Marco Island. For information: Marshall D. Brainard, 4057 Carmichael Ave., Jacksonville 32207

Cancer Conference: Annual Report—Cancer Therapy End Results at St. Joseph's Hospital, Auditorium, June 25. For information: K. E. McIntyre, M.D., 3001 W. Buffalo Ave., Tampa 33607

JULY

Polk County Medical Association Mid-Summer Meeting, July 14-19, St. Thomas, Virgin Islands. For information: T. M. Caswall, M.D., P.O. Box 927, Lakeland 33802

1976 Clinical Conference on Pre-Hospital Emergency Care, July 9-11, Orlando Hyatt House, Orlando. For information: Registrar, 1976 Clinical Conference on Pre-Hospital Emergency Care, 1919 Beachway Rd., Suite 5-C, Jacksonville 32207.

AUGUST

1976 Postgraduate Obstetric Pediatric Seminar, Aug. 10-12, Konover Hotel, Miami Beach. For information: Jorge Deju, M.D., Box 210, Jacksonville 32201

SEPTEMBER

Clinical Electrophysiology, Sept. 15-17, Wolfson Auditorium, Mount Sinai Hospital, Miami Beach. For information: CME Coordinator, Mount Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

Twenty Fourth Annual Diabetes Seminar, Sept. 17-19, Jacksonville. For information: Robert Miller, M.D., 1545 San Marco Blvd., Jacksonville 32207.

OCTOBER

First Annual Reunion, University of Miami, Department of Family Medicine, Oct. 3-5, Americana Hotel, Miami Beach*

Topics in Family Medicine 1976, Oct. 6-10, University of Miami School of Medicine, Department of Family Medicine*

17th Workshop in Electrocardiography for Cardiac Nurses & Interested Physicians, Oct. 14-18, Tides Hotel, Redington Beach, St. Petersburg. For Information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

25th Basic Colposcopy Course, Oct. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Charles B. Slack, Inc., 6900 Grove Rd., Thorofare, N.J. 08086

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel, Key Biscayne.*

FSIM/ACP Joint Fall Meeting 1976, Oct. 22-24, Marco Beach Hotel and Villas, Marco Island. For information: Florida Society of Internal Medicine, 515 Lomax St., Jacksonville 32204

1977

JANUARY

9th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-22, Carillon Hotel, Miami Beach. For information: Charles Lynne, M.D., 1200 N.W. 10th Avenue, Miami 33136

FEBRUARY

Symposium on Stroke—Moderns Trends in Cerebrovascular Disease, Feb. 9-12, Diplomat Hotel, Hollywood. For information: Mr. Ronald A. Nelson, Executor Director, Heart Association of Broward County, 440 N. Andrews Ave., Fort Lauderdale 33301

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

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WANTED: FAMILY PRACTITIONER to locate in North Florida town near Jacksonville. New office, financing available to set up practice. Write C-722, P.O. Box 2411, Jacksonville, Florida 32203.

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MISCELLANEOUS

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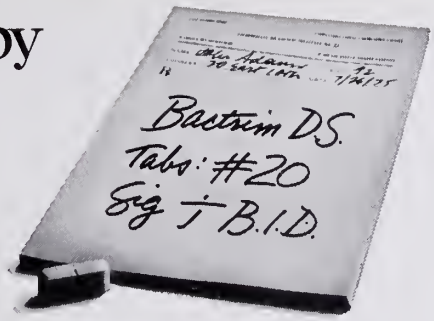
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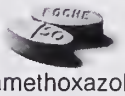


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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

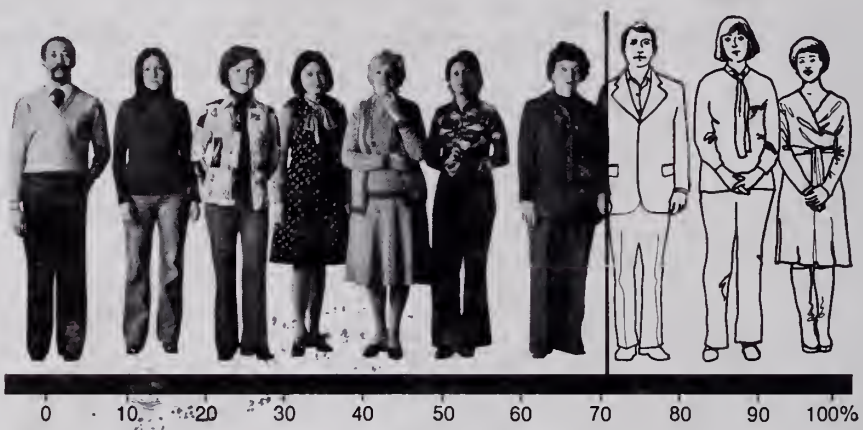
Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

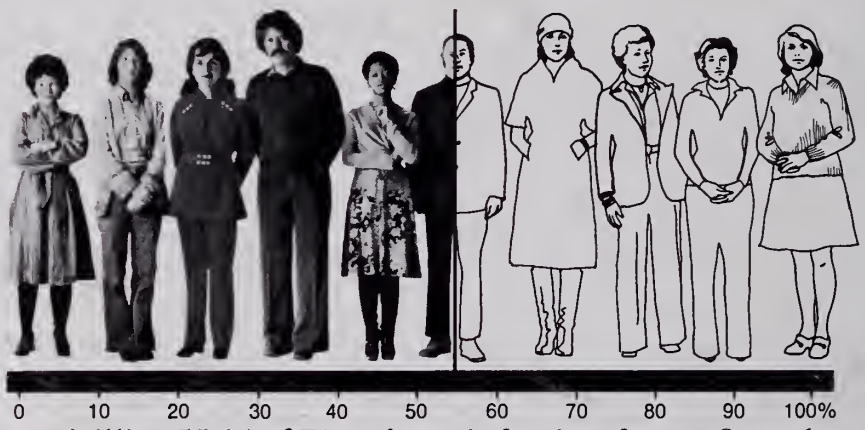
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In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets

Just 1 tablet B.I.D.

Please see summary of product information on preceding page.

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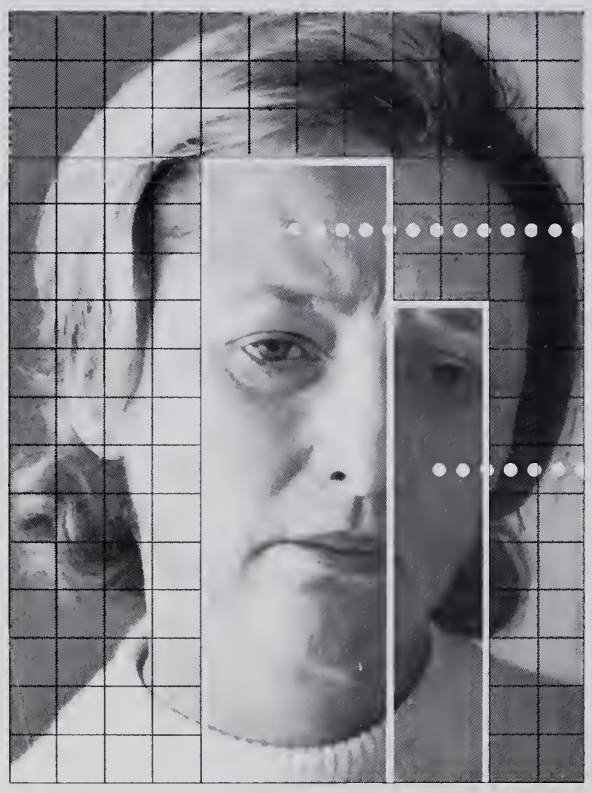
JULY 1976 • VOL 63 • NO 7



LIBRARY OF THE
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JUL 30 1976

PROCEEDINGS ISSUE

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequenc and/or severity of grand mal seizures ma require increased dosage of standard ant convulsant medication; abrupt withdrawa may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and mus cle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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This Issue

Proceedings of the 102nd Annual Meeting 479

Index to Proceedings 590

Special Articles

Physicians' Rights to Hospital Privileges
Joan L. Wollin, J.D. 553

The Real World for Doctors
Richard S. Hodes, M.D. 558

Sections

President's Page
A Stronger Role
Jack A. MaCris, M.D. 465

Books Received 573

Book Reviews 572

Dean's Page
University of South Florida Medical Center Dedication
Donn L. Smith, M.D. 468

Editorials
Acute Rheumatic Fever and Rheumatic Heart Disease
Stanford T. Shulman, M.D. 564
Contributors to The Journal Make an Interesting Cluster
E. Charlton Prather, M.D. 565

Legislative News
The Nitty Gritty
John C. Kruse, M.D. 472

Medical News Around the State 577

Organization
Summary of FMA Board of Governors Meeting, March 20, 1976 548
Summary of FMA Board of Governors Meeting, May 9, 1976 549

Others Are Saying
If you Become a Computer Kickout
Rose E. London, M.D. 569

Woman's Auxiliary
Auxiliary President's Report for Year 1975-76
Mrs. C. Brooks Henderson 578

Information

Classified Advertising 581
FMA Officers and Council Chairmen 589
FMA Officers, Councils and Committees 585
Component County Medical Societies of Florida 588
Information for Authors 573
Index to Advertisers 589
Meetings 575

July Cover — Commemorating this nation's 200th birthday is entitled "Let Us Remember, Let Us Rejoice."
This inspiring painting is a creation of Mary Alice Doff, a Jacksonville artist whose work has received many local and regional awards.



President's Page

A Stronger Role

One of the most gratifying experiences for Florida Medicine in 1975, the year of the liability insurance crisis, was the information received from a poll conducted by Civic Services, Inc. The FMA asked this firm to come into Florida, ferret out the public attitude toward medical care in this state, and give us the results as accurately as possible, so we could evaluate where we, as physicians, stood with our patients. The report was a ray of sunshine through a cloudy sky of PLI, PSRO, NHI, Medicaid, and utilization review regulations. You have been given this report, and before it is filed away it merits further consideration for several reasons.

In general, the report says that the people of Florida have confidence in their doctor, desire strongly to maintain a personal doctor-patient relationship with him, and believe that our medical care here in this country is the best in the world. Their chief concerns were the rising cost of medical care, and the erosion of a close personal relationship with their doctor.

This report is a well deserved pat on the back for Florida physicians, but just as important, it clearly points out the course we must travel in the future if we are to achieve an even better rating by our patients.

Confidence and respect are earned or destroyed on a day to day response to our patients' needs in our offices, hospitals, and in our patients' homes. It can not be significantly strengthened, or undermined by anyone but us. In spite of the waves of criticism of our health care system, the physician remains on top of every polltaker's list of professional and business people.

Cost control, on the other hand, is a more elusive problem, and much less within the grasp of the physician than the delivery of good medical care. The physician can only control his own fees, and curb unnecessary use of the system within certain limitations. He can not control the cost of labor (over 70% of hospital costs), the cost of drugs, or the cost of equipment, and should not allow himself to be placed in the position of appearing responsible for these and similar items. In an inflationary economy and a rising demand for more and better medical care, costs must necessarily rise. Even so, in a poll conducted last year, public concern regarding medical care ranks 16th among 18 items. At the present time, over 80% of the people have some form of voluntary health insurance to help meet their needs.

Government spending is generally conceded to be the primary cause for our continuing inflation, and therefore rising costs. Yet this same government threatens to take over our entire health care delivery system. It is time to challenge the tiny minority of legislators, bureaucrats, labor leaders, and social welfare planners who would impose government control over our profession, to show with reasonable certainty what betterment could come to the health care delivery system with more inflation, and an additional huge bureaucracy to further it. To date, none is apparent.

Let us continue to take the best possible care of our patients, for therein lies our strength. We will now begin to tell our story so that it will be better understood.

Jack A. Mullis, M.D.

JUST ONE CHEWABLE TABLET

usually eradicates pinworms in both children and adults



No dosage calculations

Vermox (mebendazole) offers a greatly simplified method of treating pinworm. Just one tablet, for every member of the family, regardless of weight or age.†

Simplicity of administration

Patients can take the tablet at any time. It can be chewed, swallowed, or crushed and mixed with food. No messy liquids to pour.

Not a dye

Vermox will not stain clothes, teeth, feces, toilet bowls, etc.

Highly effective

In clinical studies, the pinworm mean cure rate with Vermox was 95% (range 90-100%). In cases where reinfection occurs, a repeat tablet is advised.

Well tolerated

Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Also effective against whipworm...as well as roundworm and hookworm

Just one simple dosage, regardless of weight or age,† for single or mixed infections: 1 chewable tablet b.i.d. for 3 consecutive days. If the patient is not cured 3 weeks after treatment, a second course of treatment is advised.

†Because Vermox has not been extensively studied in children under 2 years of age, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

a single chewable tablet treatment for pinworm

Vermox

chewable tablets

TRADEMARK

(mebendazole)



DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. An insignificant amount of mebendazole is absorbed from the gastrointestinal tract. Most of this is excreted in the urine within three days either as metabolites or unchanged drug.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.
Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates mean (range)	68% (61-75%)	98% (91-100%)	96% –	95% (90-100%)
egg reduction mean (range)	93% (70-99%)	99.7% (99.5-100%)	99.9% –	– –

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE The drug has not been extensively studied in children under two years, therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.
For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.
If the patient is not cured three weeks after treatment, a second course of treatment is advised.
No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium, and co-developed by Ortho Pharmaceutical Corporation.

Ortho Pharmaceutical Corporation
Raritan, New Jersey 08869

OJ 175-6

Dean's Page

University of South Florida Medical Center Dedication

Donn L. Smith, M.D.



University of South Florida College of Medicine Medical Center

On May 21, 1976, Governor Reuben O'D. Askew dedicated the new Medical Center at the University of South Florida to the service of the people of the State of Florida.

This long awaited event climaxed the hard work and devoted efforts of a great many people including legislators, members of the Board of Regents, the Chancellor, University of South Florida officials and interested citizens in the Tampa Bay area.

It is with sincerity and humble gratitude that I am privileged to extend deep appreciation on behalf of the staff, students and faculties to all who had a part in the development of the new Medical Center.

The facilities, although not plush, are functional and esthetically pleasing. The entire Center was constructed at almost $2 million dollars below the budgeted sum and is designed for low cost maintenance.

Included in the Center are the Medical Library, the Colleges of Medicine and Nursing, cafeteria facilities, an Ambulatory Care Center, Basic Science Building, Clinical Science Building, Auditorium, Student Laboratories, and a substantial number of lecture and conference rooms.

Inasmuch as both the Colleges of Medicine and Nursing began operations in temporary quarters which were far from adequate, the patience and understanding of staff, students and faculty as they went about their work was outstanding and their enjoyment of the new quarters is well deserved.

The student body in medicine has indeed justified the hopes of the faculty and all graduates are doing quite well in their postgraduate education.

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

The faculty has also done very well during the difficult period of development. The first endowed Chair in the University has been awarded to the Department of Medicine, and the medical faculty is now the largest dollar volume producer of competitive research grants within the University. A chapter of Alpha Omega Alpha has been installed and full AMA-AAMC Liaison Council accreditation has been achieved. The College of Nursing has also moved forward and will graduate its second class in June.

While modern facilities and equipment are of great importance, the ultimate success of this Medical Center rests squarely on the shoulders of the people who inhabit the facility. A very able and effective faculty has been gathered along with a first-rate student body and a devoted staff. It is upon the activities and performance of these people that the future distinction of the Center will depend. One can be very optimistic that the University of South Florida Medical Center will indeed become an institution of distinction and will render valuable and meaningful service to the community and to the State.

The development of the State's third Medical Center has been an exciting and rewarding experience for all concerned. The support and tolerance of the medical community has played an important role and we hope for the blessing and continued support of organized medicine in the continuing efforts to develop an outstanding Medical Center.

Dr. Smith, University of South Florida, Tampa 33620.

A thousand faces
Yakking at one another.
Cocktail reception.

Escaping blizzards
At Florida meetings,
Broiled faces

Nodding heads
as if agreeing,
Soporific slides.

Narrowed vision
Focused on single track,
The 'ologist.

Senryu composed by Dr. Charles G. Eschenburg of Delray Beach.

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THE FLORIDA MEDICAL ASSOCIATION INC. 1874

Jack Nicklaus
Leasing Co., Inc.

2400 South Federal Hwy.
Delray Beach, Florida 33444

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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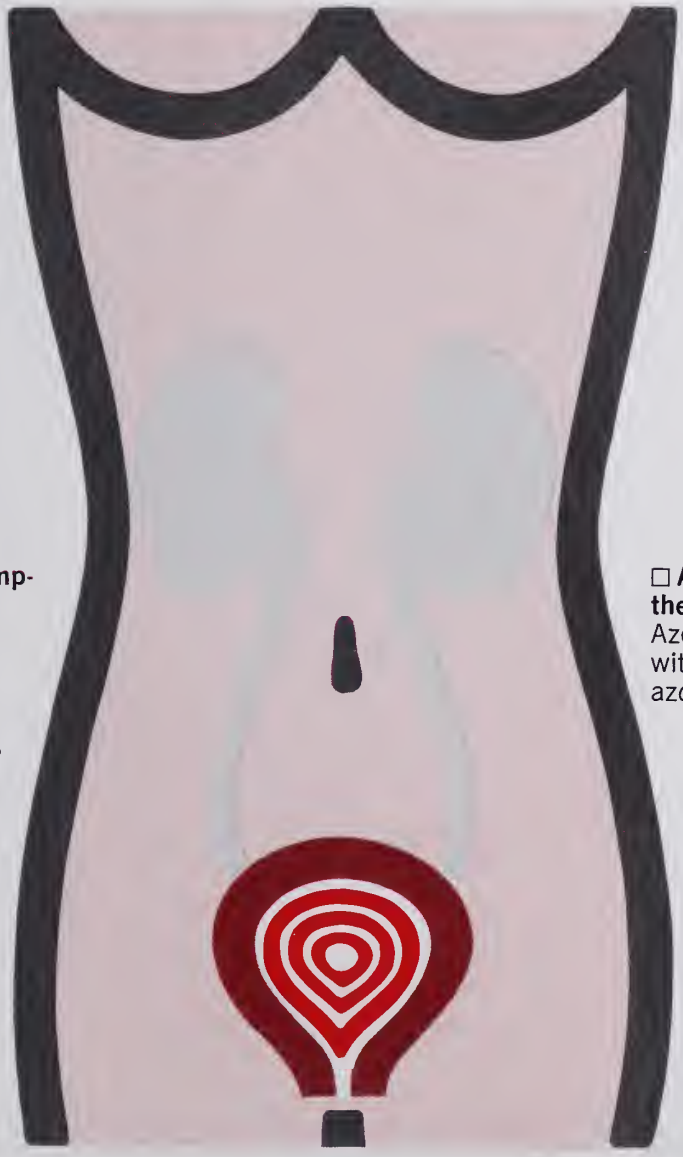
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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain for the pathogens



☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

☐ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematolo studies in cirrhotics with splenomegaly. Ar hypertensive effects may be enhanced in po sympathectomy patients. The following m occur: hyperuricemia and gout, reversible trogen retention, decreasing alkali reserve w possible metabolic acidosis, hyperglycemia a glycosuria (diabetic insulin requirements may altered), digitalis intoxication (in hypokalemi Use cautiously in surgical patients. Concomita use with antihypertensive agents may result in additive hypotensive effect. 'Dyazide' interfe with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakne dizziness, headache, dry mouth; anaphyla rash, urticaria, photosensitivity, purpura, otl dermatological conditions; nausea and vomit (may indicate electrolyte imbalance), diarrh constipation, other gastrointestinal disturbanc Necrotizing vasculitis, paresthesias, icterus, p creatitis, xanthopsia and, rarely, allergic pn monitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single U Packages of 100 (intended for institutional only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

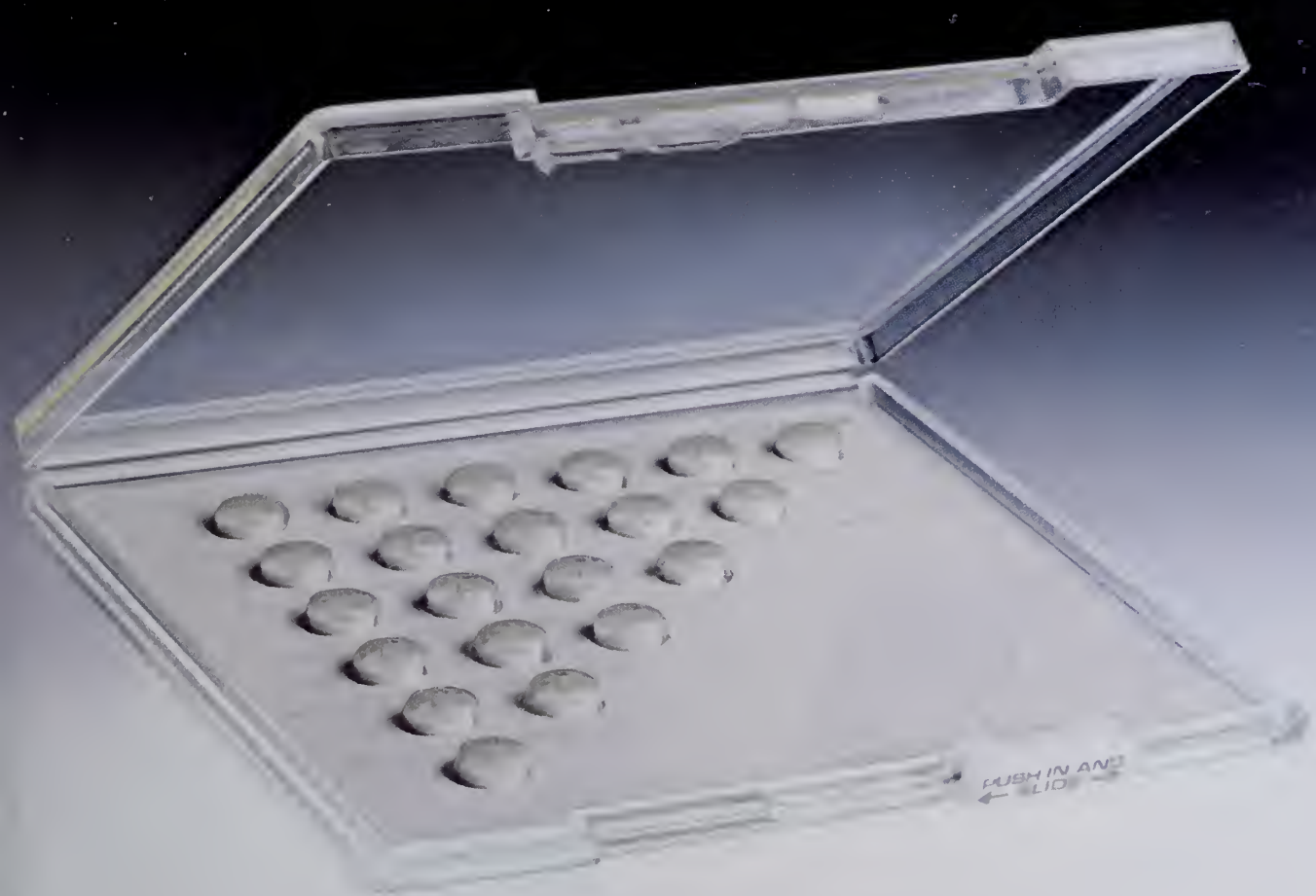
Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.





When Big Ben looks "a little off"...

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

▪ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

▪ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

▪ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

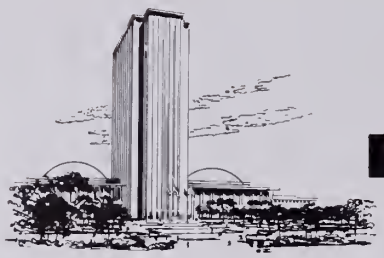
Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York New York 10017



LEGISLATIVE NEWS

The Nitty Gritty

As promised in previous months, the votes on the FMA-sponsored professional liability legislation are listed below for your perusal. These votes are indicative of our support, or lack of it, in the Legislature on this issue. The Senate voted on May 20, 1976 to adopt the so-called MacKay Bill which includes the following:

1. Remittur-additur
2. Evidentiary collateral source rule
3. Definition of negligence—burden of proof
4. Structured settlement
5. Risk Management committees can offer payment or services for a defined injury. If accepted the patient loses many of his significant rights to sue.
6. Physician must be financially responsible for posting a bond, etc.

The vote was:

Yeas—32: Mr. President; Brantley; Childers, D.; Childers, W. D.; Dunn; Firestone; Gallen; Glisson; Gordon; Graham; Henderson; Holloway; Johnston; Lane, D.; Lewis; MacKay; McClain; Myers; Peterson; Plante; Poston; Renick; Sayler; Sims; Stolzenburg; Thomas, J.; Thomas, P.; Tobiassen; Trask; Vogt; Winn; Zinkil.

Nays—6: Hair; Lane, J.; Scarborough; Spicola; Ware; Wilson.

Vote after roll call: Yea—Deeb

In the House, the vehicle for our Bills was HB 4222. Three crucial amendments were offered on May 27, 1976. The first was to strike FMA-sponsored definition of negligence-burden of proof which was offered by Rep. Moffit (D-Hillsborough). A negative vote supports the FMA. The vote was:

Yeas—24: Adams; Becker; Belanger; Burrall; Clem; Considine; Coolman; Davis; Dyer; Gersten; Hattaway; Hieber; Hill; Kiser; Langley; Moffitt; Nuckolls; Papy; Price; Richmond; Sheldon; Steinberg; Tolton; Williamson.

Nays—82: The Chair; Andrews; Barrett; Batchelor; Blackburn; Boyd; Brown; Campbell; Cherry; Clark, Dick; Clark, J. R.; Conway; Crabtree; Craig; Crenshaw; Culbreath; Dixon; Easley; Eckhart; Fechtel; Flynn; Forbes; Fortune; Foster; Freeman; Fulford; Gallagher; Gordon; Gorman; Grosse; Hagan; Hagler; Harrington; Hawkins; Hazelton; Hazouri; Healey; Hector; Hodes; Hodges; Hutto; James; Johnson; Jones; Kershaw; Knopke; Kutun; Lehman; Lewis, J. W.; Lewis, T.; Lockward; Margolis; Martin; Matthews; Mattox; Maxwell; McCall; McDonald; McKnight; Melvin; Mixson; Neal; Nelson; Nergard; Pajcic; Peaden; Poole; Poorbaugh; Redman; Richard; Rish; Robinson, G. C.; Robinson, J. W.; Rude; Ryals; Sackett; Singleton; Skinner; Smith; Thompson; Watson; Wilson.

So the FMA's position prevailed. On recovery of defense costs, Rep. Barry Richard, (D-Dade) offered our amendment. The vote was:

Yeas—79: Adams; Andrews; Barrett; Batchelor; Belanger; Blackburn; Bloom; Boyd; Brown; Burrall; Campbell; Cherry; Clark, Dick; Conway; Craig; Crenshaw; Culbreath; Davis; Dyer; Easley; Eckhart; Fechtel; Flynn; Fortune; Foster; Fulford; Gallagher; Gorman; Grizzle; Hagan; Hawkins; Hazelton; Healey; Hector; Hieber; Hodes; Hodges; Hutto; James; Johnson; Jones; Kershaw; Knopke; Kutun; Langley; Lehman; Lewis, J. W.; Lewis, T.; Lockward; Mann; Martin; Mattox; Maxwell; McCall; McDonald; McKnight; Melvin; Mixson; Morgan; Nelson; Nergard; Nuckolls; Peaden; Poole; Poorbaugh; Price; Redman; Rish; Robinson, G. C.; Robinson, J. W.; Rude; Sackett; Singleton; Skinner; Thompson; Tolton; Watson; Williams; Wilson.

Nays—22: The Chair; Becker; Clem; Considine; Coolman; Forbes; Gordon; Grosse; Harrington; Hattaway; Hazouri; Kiser; Margolis; Matthews; Moffitt; Pajcic; Richmond; Sheldon; Smith; Steinberg; Williamson; Young.

Votes After Roll Call: Yeas: Richard; Nays: Gersten.

Rep. P. Steinberg (D-Dade) offered an amendment to strike collateral source offset from the committee bill and have it apply to evidence only. Rep. Gallagher (R-Dade) moved to lay this on the table. A vote to table supports the FMA's position. The vote was:

Yeas—77: Belanger; Blackburn; Bloom; Brown; Cherry; Clark, Dick; Clark, J. R.; Conway; Crabtree; Craig; Culbreath; Dixon; Easley; Eckhart; Fechtel; Flynn; Forbes; Fortune; Foster; Freeman; Fulford; Gallagher; Gordon; Gorman; Grizzle; Haben; Hagan; Hagler; Harrington; Hattaway; Hawkins; Hazelton; Hazouri; Healey; Hector; Hieber; Hodes; Hodges; Hutto; James; Johnson; Jones; Kershaw; Knopke; Kutun; Lewis, T.; Mann; Margolis; Martin; Mattox; Maxwell; McCall; McDonald; McKnight; Melvin; Mixson; Nergard; Nuckolls; Ogden; Pajcic; Papy; Peaden; Poole; Poorbaugh; Price; Richmond; Robinson, G. C.; Rude; Ryals; Sackett; Singleton; Skinner; Smith; Thompson; Watson; Williams; Wilson.

Nays—25: The Chair; Adams; Barrett; Batchelor; Becker; Burrall; Campbell; Clem; Considine; Coolman; Crenshaw; Davis; Dyer; Kiser; Langley; Lockward; Matthews; Moffitt; Neal; Sheldon; Steinberg; Tolton; Williamson; Young.

Votes After Roll Call: Yeas: Richard, Rish; Nays: Gersten, Lehman; Nays to Yeas: Nelson.

The vote on final passage taken on May 28, 1976 in the House was:

Yeas—103: The Chair; Adams; Andrews; Barrett; Batchelor; Belanger; Bell; Blackburn; Bloom; Brown; Burrall; Campbell; Cherry; Clark, J. R.; Clem; Conway; Crabtree; Crenshaw; Culbreath; Dixon; Easley; Eckhart; Fechtel; Flynn; Fontana; Forbes; Foster; Freeman; Fulford; Gallagher; Gordon; Gorman; Grizzle; Grosse; Haben; Hagan; Hagler; Harrington; Hattaway; Hawkins; Hazelton; Hazouri; Healey; Hector; Hieber; Hill; Hodes; Hodges; Hutto; James; Johnson; Jones; Kershaw; Kiser; Knopke; Kutun; Langley; Lehman; Lewis, J. W.; Lewis, T.; Lockward; Mann; Margolis; Martin; Mattox; Maxwell; McCall; McDonald; McKnight; McPherson; Melvin; Mixson; Moffitt; Morgan; Neal; Nelson; Nergard; Nuckolls; Ogden; Pajcic; Papy; Peaden; Poole; Poorbaugh; Price; Redman; Richmond; Rish; Robinson, G. C.; Robinson, J. W.; Rude; Sackett; Sheldon; Singleton; Skinner; Smith; Steinberg; Thompson; Tolton; Watson; Williams; Wilson; Young.

Nays—6: Becker; Considine; Davis; Dyer; Gersten; Richard.

Votes After Roll Call: Yeas: Tucker, Craig, Fortune; Nays: Coolman, Moore, Williamson.

So the bill passed, as amended, and was immediately certified to the Senate after engrossment.

The two bills were then sent to a conference committee, consisting of Representatives Forbes, Lehman, Langley, Steinberg, and Senators MacKay, D. Lane, P. Thomas, and Brantley. This committee met on June 3, 1976, and agreed to a bill that permits direct collateral source offset, remittur-additur (judge may reduce excessive verdicts) structured settlements for these verdicts in excess of $200,000, a definition of medical negligence, definition of a medical expert witness, and keeping the burden of proof on the plaintiff (i.e., no res ipsa loquitor in Florida), and a much modified risk management program. The details of this bill will be in next months Journal FMA. All members of the conference committee endorsed the report to the House and Senate. The final votes were:

IN THE HOUSE

Final Voting Record in the House of Represen-Representatives on CS/SB 586

Yeas: Andrews; Barrett; Belanger; Blackburn; Bloom; Boyd; Brown; Burrall; Campbell; Cherry; Clark, J. R.; Clem; Considine; Conway; Craig; Crenshaw; Dixon; Easley; Fechtel; Flynn; Fontana; Forbes; Fortune; Foster; Freeman; Gallagher; Gorman; Grizzle; Grosse; Haben; Hagan; Hagler; Harrington; Hattaway; Hawkins; Hazelton; Hazouri; Healey; Hector; Hieber; Hill; Hodes; Hodges; Hutto; James; Johnson; Jones; Kershaw; Knopke; Langley; Lehman; Lewis, J. W.; Lewis, T.; Lockward; Mann; Margolis; Martin; Matthews; Mattox; McCall; McDonald; McKnight; McPherson; Mixson; Morgan; Neal; Nelson; Nergard; Nuckolls; Pajcic; Peaden; Poole; Poorbaugh; Redman; Richmond; Rish; Robinson, G. C.; Robinson, J. W.; Rude; Ryals; Sackett; Singleton; Skinner; Smith; Steinberg; Thompson; Watson; Williams; Wilson; The Chair.

NAYS: Adams; Batchelor; Becker; Bell; Coolman; Crabtree; Davis; Dyer; Eckhart; Gersten; Gordon; Kiser; Kutun; Moffitt; Moore; Price; Richard; Sheldon; Tolton; Williamson; Young.

Not Voting: Avon; Clark; Dick; Culbreath; Fulford; Gibson; Maxwell; Melvin; Ogden; Papy; Tucker.

Total Vote—90 yeas 21 nays — 10 n—v

IN THE SENATE

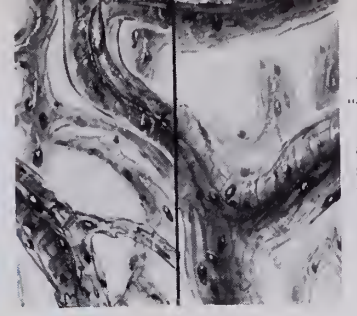
The only Senator voting against the bill was Senator Ware.

We did not pass our proposal wherein a plaintiff, if he chooses to go past a pretrial mediation panel, would be responsible for defense costs, including attorney's fees, if he subsequently lost in court. This was because the Florida Supreme Court, in its decision upholding the pretrial mediation panel passed last year, held that these panels reach "the outer limits of constitutional tolerance." As the posting of a bond for defense costs would be an additional barrier to get into court, members of both Houses felt that this would be held unconstitutional if passed.

The FMA, because of the hard work of many members and all of its staff, backed up by the key contact physicians and the willingness of all the members to assess themselves so we could have adequate help, and because we had the cooperation and support of such men as Speaker Tucker, Majority Leader Dick Clark, House Commerce Committee Chairman Forbes, Minority Leader James, President Barron, President-Designate Brantley and Senate Commerce Committee Chairman W. D. Childers, and many other Representatives and Senators, have, in the past two years, seen passed into law substantial modification of the tort system as applied to medical malpractice. Almost all the elements most people believe to be necessary to stop the skyrocketing of costs and claims have been passed. The members have a right to a sense of accomplishment and the real prospect of calmer waters ahead.

John C. Kruse, M.D., Chairman
FMA Committee on State Legislation
Jacksonville

When women outlive their ovaries...



The menopausal "flush" is believed to result from an autonomic nervous system imbalance due to estrogen deficiency. Here, illustration shows artist's interpretation of "normal" vs. dilated arteriole-capillary-venule network.

"It seemed like I was having one flush after another. It wasn't just a nuisance... it was a real problem."

The menopausal flush is the classic sign of estrogen deficiency...generally recognized as a clear indication for treatment.

This wasn't always the case.

There was a time when the symptoms of the menopause went untreated...when women were expected to suffer the severe flushes and sweats of estrogen deficiency in silence or, at best, with a minimum of encouragement and understanding.

Now, with effective estrogen replacement therapy, women do not have to endure these distressing symptoms. In the great majority of cases, PREMARIN (Conjugated Estrogens Tablets, U.S.P.) can promptly control such vasomotor symptomatology...provide classic relief for classic symptoms during a troublesome period of physiologic adjustment.

Three studies have reported an increased risk of endometrial carcinoma in association with the postmenopausal administration of exogenous estrogens. For further information see "Warnings" in prescribing information.

"The flushes were bad enough... but the sweats at night were almost too much."



For the classic symptoms of the menopause

PREMARIN®
(CONJUGATED ESTROGENS TABLETS, U.S.P.)



CONTAINS NATURAL ESTROGENS EXCLUSIVELY

See next page for revised prescribing information.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN® Brand of
CONJUGATED ESTROGENS TABLETS, U.S.P.

Actions: Estrogens are responsible for development and maintenance of the female reproductive system and secondary sex characteristics. They cause the growth and development of the vagina, uterus, and fallopian tubes, and enlargement of the breasts. Indirectly, they contribute to the shaping of the skeleton, maintenance of tone and elasticity of urogenital structures, changes in the epiphyses of the long bones that allow for pubertal growth spurt and termination, growth of axillary and pubic hair, and pigmentation of the nipples and genitals. Estrogens are also involved in psychologic and emotional aspects of feminine behavior. As estrogen levels increase during the menstrual cycle, there is a sense of vigor and well-being, and in the menopausal period estrogens aid in relieving nervous symptoms (e.g. anxiety, depression and irritability) due to estrogen deficiency. Decline of estrogenic activity at the end of the menstrual cycle can bring on menstruation, although the cessation of progesterone secretion is the most important factor in the mature ovulatory cycle. However, in the pre- or non-ovulatory cycle, estrogen is the primary determinant in the onset of menstruation. Estrogens do not induce ovulation.

Estrogens affect calcium and phosphorus metabolism, and are involved in maintenance of normal bone structure. In prolonged estrogen deficiency states, administration of estrogen acts to prevent associated bone degenerative changes.

Estrogens appear to be responsible for the relatively greater amount of alpha-lipoprotein and correspondingly lower amount of beta-lipoprotein found in premenopausal women as compared with men.

Estrogens affect the release of pituitary gonadotropins and may also deplete the gonadotropic content of the pituitary.

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium, (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.

Warnings: Three separate studies have reported an increased risk of endometrial carcinoma in association with the postmenopausal administration of exogenous estrogens. Smith *et al.*[1] retrospectively compared the records of 317 patients with endometrial carcinoma with the records of an equal number of contrast patients having cervical, ovarian, or vulvar neoplasms. The unadjusted relative risk estimate of endometrial cancer was 4.5 times greater in women exposed to estrogen therapy. The type of estrogen used, the preparation, and the dosage were not considered in this study. These factors may play a role in modifying the average relative risk found in this study. The authors also suggested that there may be a relationship between increasing risk and the duration of administration, however, the data are not conclusive on this point. A second retrospective study reported by Ziel and Finkle[2] examined the records of 94 patients with endometrial carcinoma and those of a two-fold contrast series from the same health plan population. The estimate of relative risk was found to be 7.6. In addition, the authors reported a relative risk estimate of 5.6 for a duration of exposure of 1 to 4.9 years, and 13.9 for exposure of 7 or more years. In this study, conjugated estrogens were reported to be the type of estrogen used. Mack *et al.*[3] retrospectively studied 63 cases of endometrial carcinoma and a four-fold contrast group. The relative risk of endometrial carcinoma was estimated to be 8.0 for any estrogen usage, and 5.6 for conjugated estrogen usage. The relationship between relative risk and duration of use could not be conclusively described from the data in the study.

Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed.

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations. Such physical examinations should be repeated at regular intervals, at least annually, during estrogen therapy.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Estrogen usage may cause preexisting fibromyomata to increase in size, therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
increased incidence of gallbladder disease
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN (Conjugated Estrogens Tablets, U.S.P.) should be administered cyclically (3 weeks of daily estrogen and 1 week off). There should be an annual reassessment of the patient to determine the need for continued estrogen therapy. This assessment may be assisted by lowering the dose and observing the symptoms to determine correct maintenance dosage for continued therapy.

Menopausal Syndrome—1.25 mg daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (e.g. osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg to 1.25 mg daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg to 1.25 mg or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)
No. 865—Each *purple* tablet contains 2.5 mg, in bottles of 100 and 1,000.
No. 866—Each *yellow* tablet contains 1.25 mg, in bottles of 100 and 1,000. Also in unit dose package of 100.
No. 867—Each *red* tablet contains 0.625 mg, in bottles of 100 and 1,000. Also in unit dose package of 100.
No. 868—Each *green* tablet contains 0.3 mg, in bottles of 100 and 1,000.

References: 1. Smith, D.C., Prentice, R., Thompson, D.J., and Herrmann, W.L.: Association of exogenous estrogen and endometrial carcinoma, N. Engl. J. Med. *293*:1164-1167, 1975. 2. Ziel, H.K., and Finkle, W.D.: Increased risk of endometrial carcinoma among users of conjugated estrogens, N. Engl. J. Med. *293*:1167-1170, 1975. 3. Mack, T.M., Pike, M.C., Henderson, B.E., Pfeffer, R.I., Gerkins, V.R., Arthur, M., and Brown, S.: Estrogens and endometrial cancer in a retirement community, submitted for publication.

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Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

PREMARIN®
(CONJUGATED ESTROGENS TABLETS, U.S.P.)
contains natural estrogens exclusively

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Beginning the second quarter century and exploring a wide range of subjects—from the First Conference, on *Megaloblastic Anemia,* through the Sixty-Ninth Conference, on *Iatrogenic Problems in Neonatal Intensive Care,* these conferences have provided important contributions to knowledge, stimulation of research and practice.

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This semiannual journal presents in abstract form recent periodical publication in the subject areas named.

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These informal seminars, held in collaboration with the Ambulatory Pediatric Association, provide critical presentations and discussions of common pediatric problems. These seminars have so far dealt with *Urinary Tract Infections in Childhood, Obesity in Pediatric Practice, Common Orthopedic Conditions in Childhood, Upper Respiratory Conditions in Childhood,* and *Hypersensitivity Problems in Pediatric Practice.*

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Individual booklets on various subjects to assist the physician in counseling parents in infant care, self-care and childhood behavioral complaints.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

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PROCEEDINGS

One Hundred Second Annual Meeting — Florida Medical Association, Inc.
Hollywood, May 5-9, 1976
President's Address

Medicine and The American Scene (1776-1976)

Vernon B. Astler, M.D. and Mrs. Diane Astler

Part I—The Past

If each one of us will close his eyes for two seconds and consent to travel backwards in time at the rate of 100 years per second, we can all instantly revisit a galaxy of historical and medical highlights that have affected our heritage as Americans and as physicians.

Ladies and gentlemen, the year is 1776. In Philadelphia men from the united colonies are discussing the declaration that 33-year old Virginian, Thomas Jefferson, has written. You physicians are proud to hear that your cohorts are taking an important role in the rebellion and that five physicians are among the 56 men who have agreed to risk their lives by signing this declaration. We are amazed to learn that the news of the signing of the Declaration of Independence will take 29 days to reach Charleston.

There are 2.5 million people in the colonies and we will double our population in 23 years. Almost all girls marry in their teens and consequently, the colonies are having a baby boom. Since 90% of the colonists are farmers, children are considered an economic asset. Benjamin Franklin, came from a family of 15 children.

Most professional men are not educators, scientists, or lawyers. They are ministers. Our first medical school has been in existence for only 10 years and there are fewer than 4,000 physicians in the colonies. The physicians' favorite remedy for many diseases is to bleed the patient. Small wonder that their average salary is $4.00 per day! In 1776 people amused themselves by square dancing (except in the South), fox hunting, horse racing, and cock fighting.

We can't find a single bathtub in the colonies. We do find long snouted hogs who freely roam the streets and consume refuse. We are impressed by these colonists who are remarkable people. They are brave, spirited, energetic, and independent-minded. They are freedom loving patriots. But not all colonists are freedom loving patriots. Actually,



President Vernon B. Astler, M.D., addresses the House of Delegates.

*Presented at the First Session of the House of Delegates, 102nd Annual Meeting of the Florida Medical Association, Hollywood, Fla., May 5, 1976. Dr. Astler is immediate Past President of the Florida Medical Association.

a third of the colonists are loyalists, who pledge their allegiance to England. Another third of the colonists are either apathetic or neutral about the pending war of independence. As usual, history weaves into the fabric of mankind a familiar pattern —the threads of the minority loomed the revolutionary movement.

And now if each of you will inhale deeply, we can eclipse the next few score of years to the early 1800s. It is 1826 and we note the many changes here in the United States. There are 6 million people and the cities' phalanges are spreading. In 1826 Philadelphia has a U.S. bank, New York has a three story theatre called the "Park" and North Carolina has a state supported university. Physicians are receiving their education in medical schools now rather than through apprenticeships. Their brilliance is beginning to shine with new discoveries. Dr. Ephraim McDowell performed the first ovariectomy on a 47-year-old woman, just a few years ago. This woman rode 67 miles on horseback to be operated upon and then she rode back home following her operation. Dr. Beaumont is experimenting with digestion. His patient, Alexis St. Martin, was a French Canadian guide who sustained a musket wound resulting in a large gastric fistula. Dr. Beaumont ordered raw meat, salt pork fat, salted beef, bread, and raw sliced cabbage to be fed to Alexis. He then made careful observations concerning the time and action of digestion of various foods in the stomach. Dr. Beaumont was probably the father of gastric physiology. Also in 1826 the United States is trading freely with foreign nations. Cotton, grain and tobacco are profitable export items and we are importing ginsing on the Empress of China. Ginsing is a valuable weed used to cure impotence, according to the Chinese herb doctors.

The War of 1812 is over; it will be our last conflict with England. We have nine more states in America and three physicians have been among the first governors of these new states.

Nationally we are starting to mature. We realize that we are growing up in a new world. The Old World's philosophical and psychological impact upon us is rapidly diminishing. We are assuming a definite national identification; we are proud to be Americans. The seeds of our heritage which were planted by the colonists, sprout. And now, America reaps painters who adorn their canvasses with the splendor of American landscapes. America harvests writers like Washington Irving and James Fenimore, who write enchanting stories centered about American scenes. For the first time text books are written by Americans rather than Englishmen. Yes, America is fathering sons of gargantuan stature. Sons named John Marshall, Daniel Webster, Dr. Benjamin Rush, Andrew Jackson, Henry Clay, James Monroe, and John Quincy Adams. However, our brief sojourn to the early 1800s ends now, for we still have many more highlights to focus in on.

Our next spotlight in the galaxy is aimed at the mid-1800s. It is 1847. This era brought forth a burst of innovations, discoveries, and inventions. In 1847, physicians are starring in experiments with sedatives. Heretofore, they have had to tie down their patients while operating upon them. But now, Dr. Crawford Long, from Georgia, is successfully using sulfuric ether as an anesthetic agent. Physicians are writing enlightening medical manuscripts; purpural fever is a favorite topic. Dr. Oliver Wendell Holmes, from Harvard, writes about infection in childbirth. Dr. James Sims introduces catheters so that urinary drainage will not interfere with healing following repair of vesicovaginal fistulae.

When Americans aren't working or amusing themselves, they are complaining about their ill health. They have malaria, typhoid fever, the chills, and the miseries. A baby born today has a life expectancy of 38 years. We are all ignorant about bacteria, sanitation, nutrition, and medications. Home remedies and patent medicines are used and abused by us. Dead toads are rubbed on tumors and lozenges are guaranteed to destroy worms. Despite our medical naivety, Americans are developing a mechanical sophistication. There is an explosion of new machines—the refrigerator, the sewing machine, the gasoline engine, the baby carriage, and yes, even the fountain pen is invented by Mr. Waterman. Americans are engrossed with gold in the West, new sports such as baseball, football, and items in the newspapers and magazines. They are fascinated with the new packaged powdered soap. They enjoy the New York Philharmonic, the splendid showboats on the rivers, and the colorful circus. People in the South are singing a new popular song. This song was written by an Ohioan in New York. It's called "Dixie." We physicians are forming an organization called the American Medical Association, and Elizabeth Blackwell is famous to some people because, she is the first female medical student in the United States.

And now, ladies and gentlemen, our globe spins around and we zoom in on a depressing and dismal scene. It is 1865. America's countryside is scarlet with its sons' blood. Grey gloom hangs heavy around us. Death in the Civil War strikes over a half-million

Americans indiscriminately — if not with bullets then with disease! Dysentery, small pox, yellow fever, typhoid, and pneumonia kill four times as many men as bullets during the Civil War. Presently, staph infection is regarded as a normal condition in tissue repair and laudible pus is a favorable sign of wound healing. The Civil War has also ruined the medical centers of the South. Westward expansion of the people further lowers our medical standards. The diploma mills are now surfacing. Illinois will soon have 39 medical schools and Missouri, 42 medical schools. Yes, the year is 1865. Incidentally, President Lincoln has recently appointed a physician, Dr. Samuel Miller, to the Supreme Court bench, but the President dies only five days after General Lee surrenders. America experiences its first bank robbery of any note. We are now over 30 million strong but over 20% of us are illiterate. There are half naked Indians roaming the West and there are labor unions emerging in the East.

There is just one more spot to illuminate in the 19th Century. We will pause momentarily on 1899. Our first golf course has been open for six years in Wheaton, Illinois. Americans are tapping their own resourcefulness. 440 thousand patents have been issued. Marconi invents a wireless telegraph, Edison discovers electricity, and Alexander Graham Bell has already made the first long distance phone call from New York to Chicago. We have green stamps and Kellogg Cereal at the A & P Stores. There are department stores and a ten-story skyscraper on LaSalle Street in Chicago which will make Mr. Otis a wealthy man. Railroad tracks span from sea to shining sea. Rockefeller's monopolies control 95% of all oil refineries in America. We now number over 75 million and three out of every 10 are urban dwellers. The divorce rate is one in 15. In this year of 1899 new topics for Americans are the Mayo Clinic, the Red Cross, public libraries, Boston's new trolley subway, Louis Pasteur, and Mark Twain. The YMCA has over 265,000 members. Our knowledge about bacteria is expanding and we have campaigns against public spitting. 25 thousand U.S. soldiers are returning home after fighting in the 113-day Spanish American War. Eighty per cent of these men are ill. During this war, 400 of our men lost their lives from bullets; 5,000 men lost their lives from disease! Medical schools and medical science are prospering. Twenty-two years have passed since John Babbs from Indiana removed gallstones and drained the gallbladder on a patient who survived. Cesarean sections and hernias are performed with increasing frequency. Dr. Barthalom, from Cincinnati, is experimenting with a patient's brain by mapping areas of the cerebral cortex utilizing stimulating electrodes. Dr. John Bigelow has invented an evacuator for bladder stones and described fractures of the hip in an excellent monograph. The Johns Hopkins Hospital is thriving. Presently our clinical instruction has been moved from the amphitheatre to the wards, labs, clinics, and dispensaries. Dr. Halstead performed the first radical mastectomy five years earlier. He has also just invented the first rubber operating gloves for his operating room nurse. Obviously the nurse was duly impressed as she eventually married this remarkable man. Dr. Cullen at Hopkins is developing the frozen section technique and we physicians are studying air embolism, surgery of the intestines, pancreas, and the appendix.

And in this year of 1899, Rudolph Matas from New Orleans adapted the endotracheal tube and a set of bellows so that anesthesia could be given directly into the trachea. New York physicians are charging $1.00 for an office visit and $5.00 for a consultation. Dr. J. Harrison Hodges of Gainesville, Florida, is the President of the FMA's 146 members.

Our acquaintance with the 19th Century ends now, but the spectrum of "isms" introduced to us has affected everyone of our destinies as Americans and as doctors here today. The 19th Century was the century of "isms."

It flirted with Mysticism, but it married Realism.

It spurned Dogmatism, but it embraced Darwinism.

It discovered Industrialism, but it dwelled on Humanism.

It courted Sectionalism, but it coveted Nationalism.

It met Amateurism, but it befriended Professionalism.

And now, ladies and gentlemen, the 20th Century debuts in a blaze of glory. It is 1903; blustery Teddy Roosevelt is our 26th President. Intellectual Woodrow Wilson is President of Princeton University. Andrew Carnegie, J. P. Morgan and Cornelius Vanderbilt are financial giants. We Americans are a major world power. We are enjoying peace and prosperity. Our foreign trade is over $2 billion! The Wright brothers are elated at Kitty Hawk, North Carolina, with the first successful flight of a mechanical heavier-than-air flying machine. Ford Motor Company has organized a cross country automobile trip. Fifteen per cent of our eclectic nation is foreign born. We Americans are inspired by the glorious

feats of the common man. There is an abundance of Horatio Alger stories, and men who strive do succeed. A Mr. Owens has just invented the bottle machine and a Mr. Gillette has just invented a double edged razor. The Gold Coast of Florida has less than two inhabitants per square mile. And 1903, chop suey, a dish never heard of in China, is enjoying a wave of popularity with American housewives. Medicine begins a new and illustrious era in the United States. Dr. Walter Reed and his colleagues campaign successfully to wipe out yellow fever in Cuba and the Panama Canal Zone. Medical research labs and institutions are dedicated to improving the quality of life for us Americans. We are trying to irradicate TB as it is the number one killer here, and a baby born today can expect to live for 51 years. Dr. George Crile at Western Reserve University in Cleveland is making significant discoveries involving blood pressure during surgery. Dr. Harvey Cushing is doing experimental work treating facial paralysis by grafting the spinal accessory nerve. Dr. John Murphy at Northwestern University sheds new light on grafts that reproduce the exact contour of defective bone.

Now let's glide into the milky way of this century, which is the Roaring Twenties. In 1925 there is a continuous flow of confusion and change. A social, political, and cultural upheaval is occurring in our country. Suddenly, the farmers are no longer a political majority. At the present time more than half the population is living in towns and cities. Ford automobiles which cost $290.00 are mass produced as are so many products today. Consumers are demanding goods to satisfy their tastes and desires. A credit system is established and consumption swells. Over 40 million theatre tickets are sold weekly. Charlie Chaplin, Mary Pickford, and Douglas Fairbanks are America's favorite box office stars and our sports heroes are Jack Dempsey, Bobby Jones, and Babe Ruth. There is a revolt of authors, painters, and musicians against tradition in the arts. Prohibition is here and our national drink seems to be bathtub gin. Our cities are infested with gangsters, like Al Capone, who deal in illicit liquor and racketeering. Women are shattering the Victorian ideals of femininity. The United States has more schools and students than any other nation in the world. Scientifically, our country's physicians are deeply involved in this age of discovery and inventiveness.

It is 1925 and 20 years have passed since Vedder described the use of emetine to cure amoebiasis. Twelve years ago, Schick described his test for diphtheria and Maude Slye is experimenting with hereditary susceptibility to and immunity from cancer. During World War I the mortality from tetanus was markedly reduced by the development and use of tetanus anti-toxin and the debridement and irrigation of wounds with Dakin's solution. Dr. Dandy has developed the use of ventriculography for intracranial diagnosis. Two years ago, George and Gladys Dick identified the hemolytic streptococcus as the cause of scarlet fever and they devised the susceptibility test which bears their name.

We glided into 1925; now we jet into the feverish 50s, to 1959. During the past few decades of years, we Americans witnessed the shocking of our senses and sensibilities. We struggled through a severe depression. Our industrial output halved, and our unemployment reached 15 million. Bankruptcy and foreclosures ran rampant and over one-third of our railroad mileage was bankrupt. We have been stunned with the Second World War, the Korean War, the atomic bomb, and the hydrogen bomb. We viewed the birth of the TVA, WPA, PWA, Social Security, the United Nations, transcontinental television, and jet passenger service trans-Atlantic. And now we are racing into space in 1959. Also America is becoming a nation of nomads; people are migrating to the more attractive of our 50 states. The St. Lawrence Seaway has rapidly increased the population of port cities and Fidel Castro's revolution sends a current of thousands of Cuban patriots flowing to our shores. America's physicians are undergoing an intellectual transformation. The over 500 medical schools with clinical instruction below university grade have been seriously challenged and many wiped out with the advent of the Flexner Report. Improvement rapidly followed the acquisition of medical faculties by our great universities and the establishment of full time clinical chairs. Surgery is being made pleasant and safe and 25 years have passed since the initiation of pentothal for intravenous anesthesia by Dr. John Lundy of the Mayo Clinic. A new era of cardiovascular surgery began in 1938 when Dr. Robert Gross of Boston successfully ligated a persistent ductus arteriosus. A few years later Dr. Helen Taussig and Alfred Blalock at Hopkins successfully described and surgically corrected the tetralogy of fallot. And in this year of 1959, eleven years have passed since the first intracardiac surgery was devised. Dr. Bailey of Hahnemann Hospital in Philadelphia instituted the intracardiac correction of mitral stenosis by a blind finger fracture technique. Incidentally, this courageous man almost abandoned his operative concept

after the loss of his first 12 consecutive patients! Americans benefitted from the development of many antibiotics, safe blood transfusions, and the development of great strides in the field of plastic surgery. Cardiac defibrillation has successfully been accomplished by Dr. Claude Beck in Cleveland. Hypothermia, extra corporial circulation, and synthetic vascular grafts are popularized. The awesome fear of polio vanished five years ago when Dr. Jonas Salk introduced his vaccine. FMA's membership has swollen to over 3,500 physicians under the able leadership of Dr. Ralph Jack of Miami. But the 50's have faded.

And now, ladies and gentlemen, the closest star in our galaxy dazzles before our unbelieving eyes. This imminent star that we gaze upon is 1976, the present—the here—the now.

Part II—The Present

1976—Diplomat Hotel—Grand Ballroom. Although this day dazzles, some of our recent yesterdays were deeply shadowed by the assassination of John Kennedy, Martin Luther King, and Robert Kennedy. Other days were dimmed by riots in Watts, the Kent State shootings, sit-ins at universities, and the unsettling Viet Nam War. Indeed, each of us here today has seen the black cloak of national disgrace fall over our land—when we were told to abhor the guilt of Watergate and yet ignore the shame at Chappaquidick. To be sure, we Americans have been afflicted with the disease of despair. Two years ago our nation spent over $116 billion for health care and our per capita health costs rose from $78 in 1950 to $530 in 1974. Our overemphasis on health care and utilization of medical services has not been accompanied by improvement in the health of Americans. I have reviewed data from Dr. Herman Somers which indicate that the crude death rate for the United States ceased to improve during the 1960s and into the 1970s. It has remained almost stable for over a decade. The age adjusted death rate was 9.5 per thousand in both 1960 and 1969. Breakdown of data by age and sex is even more disturbing. While we have witnessed improvement in infant mortality and length of life for females and in the control of some infectious diseases, these gains have been offset by increases in lung cancer, emphysema, cirrhosis of the liver, motor vehicular accidents, suicide, homicide, and diabetes mellitus. Yes, vehicular accidents kill 50,000 Americans annually and cirrhosis is now the ninth leading cause of death and fourth among people over age 40. Two years ago Americans spent $21.5 billion on alcohol and $13.5 billion on tobacco. Little wonder that cirrhosis, cancer of the lung, emphysema, and cardiac deaths are taking their toll.

During the 60s we witnessed a rise in death rates for every group from 15 through 44 years. Significant improvement were recorded only for those under five years and those over 75 years! Death rates of young and middle-aged American males are rising sharply! Mortality rates for white males 15 through 24 years rose 22% and for nonwhite males a shocking 42%! Leading causes for this upturn were not medically correctable illnesses, rather they resulted from vehicular accidents, suicide, and homicide! Mortality increases, smaller but still significant, apply to all white males under 45. Leading causes of death for those between 25 and 44 were the auto, homicide, lung cancer, suicide, and cirrhosis of the liver. For men between 45 and 64, there were substantial increases in deaths due to cancer of the lung, emphysema, heart and circulatory disease, and cirrhosis. A scholarly observation by Dr. Somers observes that overall death rates are stable but the productive years of life for American men are being foreshortened! Morbidity and disability in similar groups from similar causes must be inferred. There is also a revealing and rapidly increasing differential in male-female life expectancy. A female baby born in 1920 could be predicted to outlive a male by one year. In 1972 that difference had grown to 7.7 years and still is growing. This explains the rapid increase of widows in the United States. Sex differences have a greater bearing than racial differences, for the average black female baby can expect to live about a year longer than the average white male baby born today. We cannot ascribe these changes to recent genetic alterations in males and females or to more availability of health care for females. The answer seems to relate more to life styles rather than health care.

Another vanishing notion is the relationship between life expectancy and per capita income. Except among the truly impoverished, our high income groups do no better and perhaps somewhat worse than do our middle and lower middle class Americans. Again, this would seem to relate to life styles of the affluent rather than lack of health care. The mortality data reflect a clear preponderence of preventable causes, but not preventable by medical care or caused by a lack of medical care. Health should be our goal, not health systems or health delivery. Since our monies and resources are not limitless it behooves us to spend them in as practical and efficient manner as possible. Preventive health measures by

the health consumer himself may prove to be most important. Diseases such as emphysema, alcoholism, cancer of the lung, heart and circulatory disease, obesity, vehicular accidents, and others can surely be prevented or greatly reduced in frequency by the health consumer himself.

New horizons in the quality of life and the achievement of health can likely result from a study of the aging process itself and its possible physiologic control or prevention. Therefore, fellow physicians, America needs us to lead as pioneers in these reforms, for the achievement of health for her sons and daughters.

And now—if we carefully inspect America's face on her 200th Birthday, we observe that she is aging well. She smiles benevolently upon her sons and daughters who do what they think is right and do it with all their might. She cherishes that son or daughter with courage, who is willing to stand as a majority of one. She gives unselfishly to her children—mountains to marvel at—prairies to roam—gentle hills, spectacular canyons, forests, deserts, blue waters, boundless opportunities for self improvement, and above all—the freedoms our ancestors died to protect.

As physicians, we must recognize the importance of human qualities in our day to day professional relations with the sick, of sincere interest in the welfare of our patients and of fairness in financial dealings with them.

I challenge each of you to exemplify these qualities and I assure you the public trust will remain with you!

Hopefully, our nation will rally and the prognosis should brighten. As physicians, let us march in the forefront of the movement of resurgence as did our physician counterparts during the first 200 years. Let us return to the eternal verities of honor, truth, courage, individual responsibility, and love of God and country.

Ladies and gentlemen, oh say can you see by the dawn's early light what so proudly we hail. . . .

General Session

The General Session of the 102nd Annual Meeting of the Florida Association was called to order at 11:15 a.m. on Friday, May 7, 1976, in the Regency Room North of the Diplomat Hotel, Hollywood by-the-Sea, Florida, by President Vernon B. Astler, M.D.

Dr. Astler introduced the persons seated at the head table, after which he announced the winners of the awards for scientific exhibits.

1976 Scientific Exhibit Awards

FIRST PLACE: Meyer B. Marks, M.D., Miami Beach: "Stigmata of Respiratory Tract Allergies—Usual and Unusual Signs"

SECOND PLACE: Mutaz B. Habal, M.D., and Jack Maniscalco, M.D., Gainesville: "Craniofacial Correction of Severe Facial Deformities"

THIRD PLACE: John P. Christie, M.D., South Miami: "Colonoscopic Excision of Sessile Polyps"

HONORABLE MENTION: Jack E. Maniscalco, M.D., Gainesville: "Needles for Neurosurgery"

Manuel Viamonte Jr., M.D.; Raul Pereiras, M.D.; Edward Russell, M.D.; James LePage, M.D.; Patrick White, M.D.; Duane Hutson, M.D.; and Robert Zeppa, M.D., Miami Beach: "Transhepatic Portography."

Samuel Livingston, M.D.; Lydia L. Pauli, M.D.; Irving Pruce, B.S.; Herbert L. Livingston, D.D.S.; and Sumio Uematsu, M.D., Baltimore, Maryland: "Comprehensive Management of Epilepsy."

Walter H. Janke, M.D. and Ing-Sei Hwang, M.D., Ft. Lauderdale: "Surgical Management of Patients with Left Main Coronary Artery Obstruction."

John W. DeVine, M.D.; Malcolm Lesavoy, M.D.; Walter R. Mullin, M.D.; Howard A. Seider, M.D.; William B. Riley, M.D.; and John W. Little, III, M.D., Miami: "Baldness—Recent Advances."

SPECIAL HONORABLE MENTION: James R. Jude, M.D.; N.V.R. Iyengar, M.D.; Irwin Boruchow, M.D., and John B. Oak, M.D., Miami: "Heart Valve Replacement."

Dr. Astler recognized Dr. O. Frank Agee, Vice Chairman of the Continuing Medical Education Committee and commended him on the excellent job he had done in planning the scientific program for the meeting.

Dr. Astler announced that Dr. Luis Perez, Sanford, had received the Americanism Award presented by the D.A.R. and advised this was only the second time this award had been given in Florida in twenty years.

Mrs. C. Brooks Henderson, President of the Woman's Auxiliary of the Florida Medical Association, presented a check in the amount of $5,138.50 to the President of the Florida Medical Foundation, Dr. Eugene G. Peek. This contribution represented funds raised for the Foundation by the Woman's Auxiliary during the year. Mrs. Henderson recognized Mrs. Ray E. Murphy Jr., State Chairman of the Woman's Auxiliary, who was responsible for raising the funds.

Dr. Astler introduced United States Representative John J. Duncan, Tennessee, to present the annual Baldwin Lecture.

Representative Duncan explained how the present congress is trying to cope with health legislation and stated that everyone is concerned with the rising costs of medical care. Representative Duncan stated that we do not need government to set medical standards and working conditions of our profession. In the past, the Committee on Ways and Means operated without subcommittees and therefore had very little chance to cover a great many subjects. The Ways and Means Committee has now been enlarged from 25 to 37 members and has six subcommittees including one on health. Representative Duncan explained the Ways and Means Committee has jurisdiction on health and so does the Commerce Committee. One long range solution might be a separate department as proposed by the AMA which would be devoted exclusively to health. A national health care bill must be done carefully and thoughtfully and we should not promise more than we can deliver; we should be careful not to establish a program which is beyond the capabilities of the medical profession to service and government to administer, said Representative Duncan. He also advised we should not support any type of program that does not give the patient the right to choose his own doctor, hospital and the kind of treatment he does or does not want. Representative Duncan warned that current proposed health care programs would wind up straining our tax resources beyond all reason and necessity. He also stated that we must act sensibly and avoid the situations of other countries such as England and Canada by ignoring constraints imposed by limited resources, and that he felt there was no great demand for a national health care program at this time but advised that we must spread the word that this country must be alerted to any proposed national health care proposal or program that would not guarantee freedom of choice by the patient. He closed by thanking all for the strength and vitality they had given their country through the national and state medical associations.

Dr. Astler announced that the Board of Directors of the Florida Physicians Association had elected Dr. David Overbey, St. Petersburg, as the new President of FPA. Dr. Overby succeeds Dr. James T. Cook of Marianna who has headed the Florida Physicians Association since its founding a few years ago. Dr. Astler also announced that the annual general membership meeting of the Florida Physicians Association would be held at 5:00 p.m., May 7, in the Seminole Room, No. 1, and that all registered members of the FMA were invited to attend.

Dr. Astler adjourned the General Session at 12:00 noon.

First House of Delegates

The First House of Delegates convened at 4:30 p.m. on Wednesday, May 5, 1976, in the Regency Room North of the Diplomat Hotel, Hollywood by-the-Sea, Florida, with Dr. Louis C. Murray, Speaker of the House, presiding.

The invocation was given by Dr. Dean Steward, Past President of the FMA.

Dr. John H. Parker, Chairman of the Credentials Committee, reported that a quorum of 184 delegates were present and that enough counties were represented to present a quorum. Dr. Parker moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, Henry J. Babers Jr., George J. Caranasos, William B. Deal, J. C. Garlington, Gerold L. Schiebler, Joel Lipman (Student) (Absent—Thomas D. Bartley).

BAY—B. Phillip Cotton, James D. Phillips.

BREVARD—Lewis Bean, William Broussard, James E. Carter, Adrian R. Jensen, Laudie E. McHenry, Pat B. Unger.

BROWARD—Miles J. Bielek, Robert J. Brennan, Andre S. Capi, Russell B. Carson, Milton P. Caster, Burns A. Dobbins, Richard S. Doyle, Joseph E. Gelety, Theodore W. Hahn, George P. Messenger, Roland K. Molinet, Ray E. Murphy Jr., Franklin B. Ott, James B. Perry, Thomas F. Regan, Anthony J. Vento, William D. Wells, Juan S. Wester (Absent—Robert L. Andreae, Willis N. Dickens, F. Gary Gieseke, James A. Jordan, David C. Lane, Diran M. Seropian).

CAPITAL—Robert A. Johnson, Nelson H. Kraeft, Robert N. Webster (Absent—Jack W. MacDonald).

CHARLOTTE—(Absent—Melvyn Katzen, Fred Swing).

CITRUS-HERNANDO—Randall Jenkins.

CLAY—Laurin G. Smith.

COLLIER—Edwin E. Dean, Nicholas Kalvin.

COLUMBIA—(Absent—Barney E. McRae).

DADE—William G. Aten, Hilario Anido, Luis Cabrera, Sol Center, Richard Clay, Jack Q. Cleveland, Vincent Corso, O. William Davenport, Joseph Davis, Richard Dever, Charles Dunn, Isaac Egozi, Franklin Evans, A. Hernandez-Conde, Miguel Figueroa, Richard Fleming, Humberto Fontana, Ralph Frankel, L. Marshall Goldstein, Norman Gottlieb, Pedro J. Greer, Leo Grossman, Walter C. Jones III, James Jude, Marshall Hall, Henry Hardin, Joseph Harris, Robert B. Katims, Harold Kaufman, Banning G. Lary, Rose London, Harold Norman, Thomas Noto Jr., Jorge Pena, Walter Sackett Jr., Oscar Sandoval, Robert Schiess, Janice Sherwood, Everett Shocket, S. Peter Stokley, Chauncey Stone, Mario Stone, William Straight, Charles Tate, John Turner, Sheldon Zane (Absent—Morris Blau, Harvey Brown, Manuel Carbonell, Sol Colsky, Francis Cooke, Eduardo Delgado, Victor Dembrow, Joel Ehrenkranz, Ivor Fix, Raul Galliano, Stephen Glucroft, Julian Groff, Jim Hirschman, Norman Kenyon, Maurice H. Laszlo, Warren Lindau, Carlos Llanes, Arvey I. Rogers, Wayne Tobin, Dale R. Venning (Student).

DESOTO-HARDEE-GLADES—Calvin Martin.

DUVAL—Samuel J. Alford Jr., Warren M. Barrett, William P. Booras, James L. Borland Jr., Doris N. Carson, Yank D. Coble Jr., Patricia C. Cowdery, Wilbert L. Dawkins Sr., Charles P. Hayes Jr., John C. Kruse, Charles B. McIntosh, Faris S. Monsour Jr., Sanford A. Mullen, John A. Rush Jr., Jack L. Sapolsky, Guy T. Selander, William D. Walkett (Absent—William T. Haeck).

ESCAMBIA—Eric F. Geiger, John H. Whitcomb, Theodore J. Marshall, Henry M. Yonge (Absent—Reed Bell, C. Fenner McConnell).

FRANKLIN-GULF—Joseph F. Hendrix.

HIGHLANDS—Donald Hartwell, Glenn V. Hough.

HILLSBOROUGH—Frank C. Coleman, Richard G. Connar, Robert J. Courtney, I. M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Victor H. Knight Jr., Joel Mattison, Thomas E. McKell, W. Mahon Myers, John Petrakis, Ralph M. Stephan (Absent—Richard S. Hodes, Harold L. Williamson)

INDIAN RIVER—Ferdinand F. Becker (Absent—John H. Terry).

LAKE—B. F. Brokaw, Thomas Weaver.

LEE—Larry Garrett, Frances L. Howington, H. Quillian Jones Jr. (Absent—Stewart Hagen).

MADISON—(Absent—Frank Harrison).

MANATEE—Thomas R. Busard, John D. Lehman, Roger A. Meyer (Absent—Millard Quillian).

MARION—C. Brooks Henderson, Samuel L. Renfroe.

MARTIN—John F. Powers (Absent—Richard Q. Penick).

MONROE—Ronald Chase (Absent—W. M. Whitley).

NASSAU—Theodore G. Panos.

OKALOOSA—W. W. Thompson, Eugene R. Valentine.

ORANGE—Clarence C. Bailey, Clarence M. Gilbert, Paul C. Harding, Allen K. Holcomb, Rufus M. Holloway, G. Brock Magruder, Joseph G. Matthews, Franklin B. McKechnie, James F. Richards, Jr., James J. Schoeck, Thomas B. Thames, Robert E. Trumbo (Absent—Manuel J. Coto, Edward L. Farrar Jr.).

OSCEOLA—George A. Gant.

PALM BEACH—Carl Andrews, Vernon Astler, Curtis W. Cannon, Jerry F. Cox, J. Russell Forlaw, Luis Guerrero, Doris E. Lake, Charles Metzger, Richard B. Moore, Thomas Murphy, Roger Petersen, Reginald Stambaugh, Dick Van Eldik.

PANHANDLE—Herbert E. Brooks (Absent—William F. Brunner).

PASCO—Stanley Chovnick.

PINELLAS—E. Eddy Burns, Thomas M. Daniel, Charles K. Donegan, John W. Hamilton, David S. Hubbell, Morris J. LeVine, James H. Miller, Donald G. Nikolaus, David T. Overbey, Howard L. Reese, Richard D. Smith, Walter H. Winchester, Rowland E. Wood (Absent—Daniel S. Hellman, Roger A. Laughlin).

POLK—Sam J. Barranco, J. Gerard Converse, Frank J. Fischer, John Glotfelty, Willard E. Manry, Jr., Paul A. Tanner, Jr., Frank Zeller, Jr. (Absent—Thomas M. Caswall).

PUTNAM—(Absent—Charles E. Barrineau).

ST. JOHNS—W. W. O'Connell.

ST. LUCIE-OKEECHOBEE—Howard C. McDermid (Absent—William Meyer).

SANTA ROSA—(Absent—William Watson).

SARASOTA—John N. Carlson, Kenneth C. Kiehl, Douglas Murphy, Franklin Pfeiffenberger, Karl R. Rolls, Robert E. Windom.

SEMINOLE—(Absent—John Johnson, Luis Perez).

SUWANNEE-HAMILTON-LAFAYETTE—Larry Radkins.

TAYLOR—John H. Parker, Jr.

VOLUSIA—James Carratt, Richard Dillard, Richard Snodgrass, William H. Harrison (Absent—Octavius B. Bonner).

WALTON—(Absent—Howard F. Currie).

SPEAKER OF THE HOUSE—Louis C. Murray.

VICE SPEAKER—Charles J. Kahn.

Information for Delegates

The Rules and Order of Business for the House of Delegates is included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at **each** meeting of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Wherever possible, it is requested that resolutions and supplemental reports be forwarded to the Association's executive office by April 28 for duplication and distribution to the delegates.

All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

A resolution before the Reference Committee must have a sponsor present before the Reference Committee. All resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be duplicated and available at the Reference Committee meetings when they convene. Only the "Resolved" portion of resolutions will be adopted as policy. Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House.

We also plan to have all Reference Committee reports duplicated and available to the delegates at the Registration Desk on the morning of the day the Second House of Delegates meets in the afternoon. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, as well as those which will be in the Delegates' Packets and the reports of the Reference Committees, have been color coded for easy reference. This color code is as follows:

REFERENCE COMMITTEE NO. I — GREEN
REFERENCE COMMITTEE NO. II — BUFF
REFERENCE COMMITTEE NO. III — BLUE
REFERENCE COMMITTEE NO. IV — PINK
REFERENCE COMMITTEE NO. V — GOLDENROD

According to our By-Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented to the House, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Louis C. Murray, Speaker
House of Delegates
Charles J. Kahn, Vice Speaker
House of Delegates

No corrections were made in the Proceedings of the 1975 House of Delegates, which were published in the July 1975 issue of the Journal of the Florida Medical Association.

A motion carried to approve the minutes of the 1975 House of Delegates.

A motion carried to approve the minutes of the Interim Meeting held January 30-February 1, 1976, published in the Journal of the Florida Medical Association in March 1976.

Dr. Murray, Speaker, advised that Dr. William Rowlett, Past President, had departed this life on July 29, 1975. In his memory, roses have been placed at each end of the Speaker's podium. Dr. Murray asked the House to observe a moment of silent prayer out of respect and memory of Dr. Rowlett.

The Speaker introduced the officers of the Association: Drs. Vernon B. Astler, President; Jack A. MaCris, President-elect; Thad Moseley, Immediate Past President; Irving M. Essrig, Vice President; James W. Walker, Secretary; Charles J. Kahn, Vice Speaker; and Dr. W. Harold Parham, Executive Vice President.

The Speaker instructed the House.

Remarks of the Speaker

Mr. President, Officers and Members of the House of Delegates of the Florida Medical Association. In this year 1976 during which our nation celebrates its bicentennial, we, as physicians, are at the crossroads of decision-making in developing the proper policies to guide our Association for years to come. The professional liability crisis and the weight of governmental programs including the establishment of HSA's make it more incumbent than ever before that we accept the responsibility to act in a positive way, to carefully consider all of the proposals before us, participate actively in reference committee proceedings by expressing all of your views and opinions with the hope that the final proposals brought back to the House will reflect a course of action that you can support, vote for and implement. Whatever policies are developed by this body must be carried forward by the 10,500 members of the FMA. This can only be done by going back home and organizing your fellow members; therefore, after you leave here your responsibilities to supply leadership back home continue since the problems we are beset with will continue.

This challenge to you, our delegates, to continue the fight back home to see that the policies we pass here do not become dust-covered, forgotten pages in a file, but become a rallying point for a plan of cohesive and positive action which will protect, maintain and improve the best system of health care in the world.

We all must feel and well know why we are fighting to preserve our system of health care, not for you, not for me, but for the recipients of the system—our patients.

So, consider all the issues, vote out the policy; then let your voices be heard in carrying out what you vote out. Also, remember that to do nothing can be the most dangerous policy of all.

Your Speaker and Vice Speaker stand ready and available to assist you in any way possible.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

Dr. Murray introduced Mr. Jack W. Herbert, President, Blue Shield of Florida, Jacksonville; E. Charlton Prather, M.D., Director, Health Program Office, Tallahassee; Mrs. William H. Harrison, President-Elect, Woman's Auxiliary to the Florida Medical Association and Mrs. C. Brooks Henderson, President, Woman's Auxiliary to the Florida Medical Association. Mrs. Henderson was invited to make a few remarks.

Mrs. Henderson advised this was the Golden Anniversary of the Woman's Auxiliary to the Florida Medical Association and also that the Florida Woman's Auxiliary ranked sixth among the 50 states. Mrs. Henderson summarized the accomplishments of the Auxiliary during the past year and stated that special emphasis had been placed on legislation and public relations. Mrs. C. H. Gilliland, Secretary of the American Medical Association Auxiliary, Gainesville; and Mrs. L. W. Hewit, Tampa, President-Elect of the Southern Medical Association were introduced by Mrs. Henderson.

Dr. Murray requested Dr. Calvin Martin and Dr. Henry Babers to escort Dr. Gordon Henry McSwain, Arcadia, to the podium to receive the A. H. Robins Company Award for "Outstanding Community Service by a Physician."

A. H. Robins Company Award
"For Outstanding Community Service By A Physician"

Gordon Henry McSwain, M.D., of Arcadia, whose life has been dedicated to public service, civic improvements, protection of the environment and the faithful practice of medicine, has been elected to receive the 1976 A. H. Robins Company Award for Outstanding Community Service by a Florida Physician.

Each year, the Board of Governors faces the difficult task of singling out a member of the Florida Medical Association for this honor from nominees proposed by FMA's county medical societies. Recipients are selected on the basis of services rendered to their communities.

A mere glance at the long list of Dr. McSwain's activities and accomplishments leaves no doubt that he has given generously of himself to his profession, and to the cultural, civic, and social wellbeing of his native and beloved Arcadia.

Gordon McSwain was born in Arcadia 70 years ago and received his early education in the public schools there. He graduated from Davidson College in 1928 and received his M.D. degree from Harvard Medical School in 1932. He served a two-year internship at Charity Hospital and began his medical practice in 1934 in Arcadia. He has practiced faithfully in that community since that time except for a span of three and one-half years during World War II, when he served in the United States Army Medical Corp. Following his return from the Army, he resumed the private practice of medicine in Arcadia.

As a member of organized medicine, Dr. McSwain has served as a member of the medical staff at Arcadia General Hospital, and at one time or another, in all official capacities on the medical staff.

Dr. McSwain is a life member of the Florida Medical Association and served for many years on the Membership and Discipline Committee. He has served as President of the DeSoto-Hardee-Glades County Medical Society on several occasions. He is a fellow of the American College of Surgeons.

Some of Dr. McSwain's greatest contributions to the community have come at a time when other men might see a decrease in activity and a leveling off to retirement. Not so with Dr. McSwain. Five years ago he led the medical staff of the DeSoto Medical Hospital in Arcadia in a successful effort to create one of the first special care and coronary care units in a small hospital in the state of Florida. This was an uphill battle requiring the tenacity of a bulldog and the force of a Sherman tank, but has resulted in immeasurable benefits to the community in terms of better medical care, decreased cardiac mortality rate and a sense of pride and accomplishment for the hospital.

Dr. McSwain organized and worked through the hospital medical staff and the local medical society, an ongoing program in cardiopulmonary resuscitation. He has devoted many hours of his personal time to the actual training and supervision of training courses. Through his efforts, the local medical society developed a program of certification for demonstrated competency in cardiopulmonary resuscitation. He not only extends this service to professionals and allied care personnel, but to individuals throughout the community. Dr. McSwain is a member of the CPR Committee of the Florida Heart Association and is currently organizing a local unit of the Florida Heart Association in DeSoto County.

As impressive as Dr. McSwain's professional credentials are, his civic activities are equally imposing.

Dr. McSwain began his career of public service early in his professional career. He began as a member of the Kiwanis Club and served as its president in 1938. He has served as member of the Board of Deacons at the First Presbyterian Church for the last 35 years.

Dr. McSwain was founder and charter member of the Arcadia Country Club. He was also an organizer of the Peace River Valley Historical Society and served as its first president.

Dr. McSwain's endless efforts to improve his community while preserving the ecological aspects of the city has been an ongoing crusade. He has worked faithfully to preserve the beauty of the city against destructive forces that would place expediency before serious consideration of long-term effects. Dr. McSwain has led public campaigns to prevent destructive abuse of public parks and the wholesale removal of the beautiful trees that are present in Arcadia.

At the present time, Dr. McSwain is working on a compendium of home remedies entitled "Cracker Cures."

Dr. and Mrs. McSwain, the former Lewellyn Best, are the parents of three married daughters and nine grandchildren.



Gordon H. McSwain, M.D., of Arcadia, is escorted to podium by Henry J. Babers, M.D., Gainesville (left), and Calvin W. Martin. M.D., Arcadia, to receive the A. H. Robins Company Award for Outstanding Community Service by a physician.

Dr. McSwain expressed his appreciation for the award and noted special thanks to his County Medical Society.

Dr. Murray read a telegram of congratulations addressed to Dr. McSwain from W. L. Zimmer, III, President, A. H. Robins Company. Dr. Murray also recognized Mr. B. T. Whitefield Jr., Lake Worth, as the A. H. Robins Company Representative.

The Speaker announced that the members of the Reference Committees are published in the Handbook. He asked that William Straight, M.D. replace Joseph Davis on Report No. 2.

Dr. Murray introduced the President, Dr. Vernon B. Astler, to deliver his address to the House. Before delivering his address, Dr. Astler read a communication advising that the Supreme Court of Florida had upheld Mediation Panels as constitutional. Dr. Astler announced that since this was America's Bicentennial year that he was changing the format of the President's Address and had invited his wife, Diane, to present the Address with him.

The President's Address was assigned to Reference Committee No. III.

The Speaker announced the assignment of AMA Delegates to the Reference Committees and that the Meetings of the Reference Committees would be as assigned in the Handbook. Dr. Murray announced that the assignment of Reports and Resolutions were as printed in the Handbook with no changes.

The Vice Speaker announced the assignment of Supplemental Reports and Resolutions received too late for inclusion in the Handbook as follows:

Reports	Assigned to Reference Comm. No.
Committee on Allied Health Professions	II
Council on Scientific Activities	I
Council on Legislation and Regulations	IV
Council on Medical Services	II

The Vice Speaker, Dr. Kahn, advised that if there was no objection reports and resolutions would be assigned as published in the Handbook. No objection was raised. Dr. Kahn announced that additional reports from the floor of an emergency nature only, must be by unanimous consent and must be in writing. There were none.

The Vice Speaker announced that the Florida Physicians Association would sponsor a seminar on Labor Law at 8:45 a.m. Friday, in the Regency Room West and that the program would be divided into two segments; one, Unions and Labor Law, and two, Private Physicians and Federal Labor Law Affecting His Employees. Other announcements of meetings were:

Blue Shield Annual Meeting, Thursday, May 6, 8:00 a.m., in the Regency Room North.

General Session, Friday, May 7, 11:00 a.m., in the Regency Room North.

FLAMPAC-Auxiliary Luncheon, Friday, May 7, 12:15 p.m., in the Cafe Cristal/Les Ambassadeurs Dining Room.

The First House of Delegates recessed at 5:45 p.m., to reconvene on Saturday, May 8, at 3:00 p.m.



Preparing to enjoy their annual breakfast get-together were these Past Presidents of FMA. Seated, left to right: Jack Q. Cleveland, M.D., Coral Gables (1968); James T. Cook, M.D., Marianna (1970); Henry J. Babers, M.D., Gainesville (1969); Jere W. Annis, M.D., Lakeland (1958); George S. Palmer, M.D., Tallahassee (1966); and Joseph C. Von Thron, M.D., Cocoa Beach (1973). Standing: Thad Moseley, M.D., Jacksonville (1974); H. Phillip Hampton, M.D., Tampa (1965); Leo M. Wachtel, M.D., Jacksonville (1960); W. Dean Steward, M.D., formerly of Orlando, now of Marianna (1967); Ralph W. Jack, M.D., Miami (1959); and William J. Dean, M.D., St. Petersburg (1972).

Second House of Delegates

The second meeting of the House of Delegates convened at 3:00 p.m., Saturday, May 8, 1976, in the Regency Room North of the Diplomat Hotel, Hollywood by-the-Sea, Florida, with Dr. Louis C. Murray, Speaker of the House, presiding.

Dr. John H. Parker, Chairman of the Credentials Committee, reported that 232 delegates were present with 38 counties represented, constituting a quorum, and moved the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, Henry J. Babers Jr., Thomas D. Bartley, George J. Caranasos, William B. Deal, J. D. Garlington, Gerold L. Schiebler, Joel Lipman (Student).
BAY—B. Phillip Cotton, James D. Phillips.
BREVARD—Lewis Bean, William Broussard, James E. Carter, Adrian R. Jensen, Laudie E. McHenry, Pat B. Unger.
BROWARD—Miles J. Bielek, Robert J. Brennan, Bruce B. Burgess, Andre S. Capi, Russell B. Carson, Milton P. Caster, Willis N. Dickens, Burns A. Dobbins, Richard S. Doyle, Joseph E. Gelety, F. Gary Gieseke, James A. Jordan, David C. Lane, George P. Messenger, Roland K. Molinet, Ray E. Murphy Jr., Franklin B. Ott, James B. Perry, Thomas F. Regan, Diran M. Seropian, Anthony J. Vento, William D. Wells, Juan S. Wester (Absent—Theodore W. Hahn).
CAPITAL—Robert A. Johnson, Nelson H. Kraeft, Robert N. Webster (Absent—Jack W. MacDonald).
CHARLOTTE—Melvyn Katzen (Absent—Fred Swing).
CITRUS-HERNANDO—Randall Jenkins.
CLAY—Laurin G. Smith.
COLLIER—Edwin E. Dean, Nicholas Kalvin.
COLUMBIA—(Absent—Barney E. McRae).
DADE—Joseph Amdur, Edward Annis, William G. Aten, Jose Bocles, Luis Cabrera, Edmund Cava, Sol Center, Richard Clay, Jack Q. Cleveland, Vincent Corso, O. William Davenport, Richard Dever, John Devine, Charles Dunn, Isaac Egozi, Franklin Evans, A. Fernandez-Conde, Miguel Figueroa, Humberto Fontana, Ralph Frankel, Milton Goldman, L. Marshall Goldstein, Norman Gottlieb, Pedro J. Greer, Julian Groff, Leo Grossman, Walter C. Jones III, James Jude, Henry Hardin, Joseph Harris, Robert B. Katims, Harold Kaufman, Banning G. Lary, Maurice H. Laszlo, Warren Lindau, Carlos Llanes, Rose London, Richard Miller, Stanley Mitchel, Moises Mitrani, Miguel Mora, Modesto Mora, Harold Norman, Thomas Noto Jr., Jorge Pena, Walter Sackett Jr., Robert Schiess, Janice Sherwood, Everett Shocket, Margaret Skinner, S. Peter Stokley, Chauncey Stone, Mario Stone, William Straight, Charles Tate, John Turner, Dale R. Venning, Sheldon Zane (Absent—Hilario Anido, Harvey Brown, Joseph Davis, Victor Dembrow, Richard Fleming, Marshall Hall, Norman Kenyon, Oscar Sandoval).
DESOTO-HARDEE-GLADES—Calvin Martin.
DUVAL—Samuel J. Alford Jr., Warren M. Barrett, William P. Booras, James L. Borland Jr., Doris N. Carson, Yank D. Coble Jr., Patricia C. Cowdery, Wilbert L. Dawkins Sr., Emmet F. Ferguson Jr., Charles P. Hayes Jr., John C. Kruse, Charles B. McIntosh, Faris S. Monsour Jr., Sanford A. Mullen, John A. Rush Jr., Guy T. Selander, William D. Walkett (Absent—Jack L. Sapolsky).
ESCAMBIA—Reed Bell, Theodore J. Marshall, C. Fenner McConnell, John H. Whitcomb (Absent—Eric F. Geiger, Henry M. Yonge).
FRANKLIN-GULF—(Absent—Joseph P. Hendrix).
HIGHLANDS—(Absent—Donald Hartwell, Glenn V. Hough).
HILLSBOROUGH—Frank C. Coleman, Richard G. Connar, Robert J. Courtney, I. M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Richard S. Hodes, Donald Irvine, Victor H. Knight Jr., Thomas E. McKell, W. Mahon Myers, John Petrakis, Ralph M. Stephan, Harold L. Williamson.
INDIAN RIVER—John H. Terry (Absent—Ferdinand F. Becker).
LAKE—B. F. Brokaw, Thomas Weaver.
LEE—Larry Garrett, Stewart Hagen, Frances L. Howington, H. Quillian Jones Jr.
MADISON—(Absent—Frank Harrison).
MANATEE—Walter Graham, John D. Lehman, Roger A. Meyer (Absent—Thomas R. Busard).
MARION—C. Brooks Henderson, Samuel L. Renfroe.
MARTIN—Richard Q. Penick (Absent—John F. Powers).
MONROE—Ronald Chase (Absent—W. M. Whitley).
NASSAU—Theodore G. Panos.
OKALOOSA—W. W. Thompson, Eugene R. Valentine.
ORANGE—Clarence C. Bailey, Michael Ballard, Stephen A. Butler, Clarence M. Gilbert, Paul C. Harding, Allen K. Holcomb, Rufus M. Halloway, G. Brock Magruder, Joseph G. Matthews, Franklin B. McKechnie, James G. Richards Jr., James J. Schoeck, Thomas B. Thames, Robert E. Trumbo.
OSCEOLA—George A. Gant.
PALM BEACH—Carl Andrews, Vernon Astler, Curtis W. Cannon, J. Russell Forlaw, Luis Guerrero, Doris E. Lake, Charles Metzger, Richard B. Moore, Thomas Murphy, Roger Petersen, Reginald Stambaugh, Dick Van Eldik (Absent—Jerry F. Cox).
PANHANDLE—Herbert E. Brooks, William F. Brunner.
PASCO—Stanley Chovnick.
PINELLAS—E. Eddy Burns, Thomas M. Daniel, Charles K. Donegan, John W. Hamilton, David S. Hubbell, Roger A. Laughlin, Morris J. LeVine, James H. Miller, James M. Neill, Donald G. Nikolaus, David T. Overbey, Howard L. Reese, Walter H. Winchester, Rowland E. Wood (Absent—Richard D. Smith).
POLK—Sam J. Barranco, J. Gerard Converse, John Glotfelty, Wiley Koon, Willard E. Manry Jr., Paul A. Tanner Jr., Frank Zeller (Absent—Frank J. Fischer).
PUTNAM—Roy E. Campbell.
ST. JOHNS—W. W. O'Connell.
ST. LUCIE-OKEECHOBEE—Howard C. McDermid, William Meyer.
SANTA ROSA—(Absent—William Watson).
SARASOTA—John N. Carlson, Kenneth C. Kiehl, Douglas Murphy, Franklin Pfeiffenberger, Karl R. Rolls, Robert E. Windom.
SEMINOLE—John Johnson, Luis Perez.
SUWANNEE-HAMILTON-LAFAYETTE—Larry Radkins.
TAYLOR—John H. Parker Jr.
VOLUSIA—Octavious B. Bonner, James Carratt, Richard Dillard Richard Snodgrass, William H. Harrison.
WALTON—(Absent—Howard F. Currie).
SPEAKER OF THE HOUSE—Louis C. Murray.
VICE-SPEAKER—Charles J. Kahn.

The President, Dr. Astler, announced there would be a special Executive Session of the House for a special report of the officers to the membership immediately after the adjournment of the second meeting of the House of Delegates.

Dr. Astler called Dr. Emily Gates of the Department of Health and Rehabilitative Services and Dr. Cal Brooks of the Department of Education to the podium for a special presentation of a plaque of

appreciation to Dr. Wesley S. Nock, Coral Gables, for his many years of service as a committee member and Chairman of the School Health Advisory Committee of the Florida Medical Association. Dr. Brooks read a letter of appreciation to Dr. Nock from Mr. Benton Clifton, Administrator of the School Health Program, Department of Education, thanking Dr. Nock for his dedicated service to the School Health Advisory Committee. Dr. Robert B. Katims, Miami, accepted the plaque in the absence of Dr. Nock, who was unable to attend due to a scheduling problem.

The President introduced Congressman Bill Gunter, candidate for State Treasurer and Insurance Commissioner, and asked Congressman Gunter to come to the podium to briefly address the House.

Congressman Gunter expressed his thanks for the opportunity to greet all present and commended the members for their professional liability program currently under consideration in Tallahassee.

Dr. Astler requested the Deans of the Medical Schools or their representatives to come to the podium for presentations to the medical schools of unrestricted contributions from the AMA-ERF. Mrs. C. Brooks Henderson, President of the Woman's Auxiliary, made the presentations.

Dr. William Deal, Associate Dean, accepted the contribution of $9,937.24 on behalf of the University of Florida College of Medicine. A check for $9,243.84 was presented to Dr. Donn L. Smith, Dean, University of South Florida for the College of Medicine. Dr. Emanuel M. Papper, Dean, University of Miami School of Medicine, accepted a check for $6,084.67, and Paul R. Elliott, Ph.D., Director of Program in Medical Science, accepted a check for $2,943.89 for Florida State University.

Dr. W. Harold Parham, Executive Vice President, presented Prints Nos. 101, 102 and 103 of the "Caduceus" painting by Lee Adams to the Deans of the medical schools for their personal use.

Dr. Astler called for Congressman Paul G. Rogers to come to the podium to receive the Distinguished Layman Award.

A Resolution Honoring Congressman Paul G. Rogers United States Congress

Distinguished Layman Award

WHEREAS, Congressman Paul G. Rogers is now serving his fifth year as Chairman of the House Public Health and Environment Subcommittee, his eleventh term in Congress, and has become nationally known as an innovative and hardworking leader; and

WHEREAS, He is the author or sponsor of virtually every major law in the area of health; and

WHEREAS, Congressman Rogers authored the National Cancer Act of 1971 and the National Heart and Lung Act of 1972, both which were designed to encourage research into the causes of the nation's two top diseases, as well as the Emergency Medical Services Act and the Health Maintenance Organization Act, which are all prominent pieces of health legislation which bear the Rogers name; and

WHEREAS, Congressman Rogers continues his keen interest in conservation and environment as a member of the Merchant Marine and Fisheries Committee, where he was a sponsor of the Sea Grant Colleges Act and the Ocean Dumping Act to restrict the pollution of the oceans; and

WHEREAS, Congressman Rogers has taken a leadership role in the fight against drug abuse, authoring the 1970 Comprehensive Drug Abuse Act and guided into law legislation creating the President's Special Action office for Drug Abuse Prevention; and his Community Mental Health Centers Act provides treatment; and

WHEREAS, Congressman Rogers' work in health legislation has resulted in many awards and honorary degrees; and he has been recognized as an outstanding statesman and public servant by a diverse spectrum of civic, educational and professional organizations; and he has received such awards as: the Freedom Heritage Award of the Florida Academy of Physicians, Medical Tribune Health Award for Meritorious Service in the Field of Health, Annual Legislative Service Award from the National Association of State Drug Abuse Program Coordinators, Layman's Citation for Distinguished Service from the American Medical Association and the Papanicolaou Cancer Research Institute's Statesman Award; and

WHEREAS, Congressman Rogers continues to serve the citizens of Florida and the United States as Congressman, a position from which he plays a leading role in contributing to the advancement of the ideals of the profession of medicine; therefore be it

RESOLVED, That upon the unanimous vote of the Board of Governors, the Florida Medical Association, at its 102nd Annual Meeting at Hollywood, Florida, May 5-9, 1976, present to Congressman Paul G. Rogers its Distinguished Layman Award.

Congressman Rogers stated that he was most honored to receive the award and that it was most gratifying to receive such an award from one's own state and from such a distinguished group. He said that in a spirit of cooperation we are all working to continue and to improve the best medical care in the world.



Congressman Paul Rogers of West Palm Beach was named recipient of FMA's fourth Distinguished Layman Award. Here he receives the framed citation from FMA President Vernon B. Astler, M.D.

The President recognized the Alachua County Medical Society Student Delegate, Joel Lipman, representing the University of Florida College of Medicine.

Resolution From the Board of Past Presidents

A Tribute of Appreciation to W. C. Roberts, M.D.

FMA HOUSE OF DELEGATES

May 7, 1976

WHEREAS, Dr. William C. (Hogg) Roberts, a distinguished Past President of the FMA, has attended every meeting of its House of Delegates for 30 years, lending a distinct flavor to these meetings with his wit, his wisdom, his dynamic personality and his outstanding leadership;

WHEREAS, illness has unfortunately prevented Dr. Roberts from attending this meeting, now therefore be it

RESOLVED, That this House of Delegates sincerely regrets his unfortunate disability and wishes him a speedy recovery, and early return to the sessions of this House and accord him a standing vote of acclaim and affection and be it further

RESOLVED, That this resolution be spread in the minutes of this Association, and a copy be delivered expeditiously to Dr. Roberts by appropriate members of the Bay County Medical Society.

Adopted by acclamation by the House of Delegates May 8, 1976.

The Speaker introduced Dr. James Walker, President, PIMCO, for a status report concerning the Florida Medical Association's Professional Liability Insurance Trust.

Dr. Walker reported that the Trust has been in operation for five months and is on target and now operating very smoothly. He stated that this is the largest casualty insurance agency in Florida and that they had come through the crunch of underwriting some 5,000 applications with approximately 4,000 members in the Trust at the present time. Dr. Walker stated the Trust was backed up by Lloyds of London and staffed with the finest and most qualified persons available, and that Florida is the only state in the Union that has Trust legislation and the Association is the only group in America that has its own agency to administer this Trust. Dr. Walker commented on two points; one, that the mediation panels had been declared constitutional by the Supreme Court; and two, that the 1977 rate structure is not known as yet and figures will not be available until August 1. Dr. Walker recognized the Trustees, Drs. Astler, MaCris, Hodes and Davenport who have served without compensation and given unselfishly of their time, and Dr. W. Harold Parham, Executive Vice President, who serves as Agent for the Trustees and Chairman of the Board. Dr. Walker thanked the members for the privilege of having served as an officer in the past and pledged to do his best in their behalf as President of PIMCO.

The Speaker announced a minor procedural change to avoid some of the confusion encountered in the past in negative statements regarding Reference Committee Reports. All Reports and Resolutions will only become main motions before the House when they are reported back by the Reference Committee to the House as a motion. All Reports will be moved in a positive and not in a negative manner.



Officials of Florida's three medical schools proudly display prints of the Lee Adams painting "Caduceus" which were given to them by Florida Medical Foundation. Left to right: Mrs. C. Brooks Henderson of Ocala, President of the FMA Auxiliary; Emanuel M. Papper, M.D., Dean, University of Miami School of Medicine; Donn Smith, M.D., Dean, University of South Florida College of Medicine; and William B. Deal, M.D., Associate Dean, University of Florida College of Medicine.

Report of Reference Committee No. I
Health and Education

Dr. Thomas E. McKell, Chairman of Reference Committee No. 1, came forward to present the report of the committee.

Council on Scientific Activities

The motion of the Reference Committee to commend the Medical School Advisory Committees for their excellent work carried.

The motion of the Reference Committee to commend Dr. Gerold L. Schiebler for his outstanding proficiency as Editor of **The Journal of the Florida Medical Association,** including a special note of the **Dermatology Issue** and the innovative work in the expansion of the panel of consultant reviewers for **The Journal** carried.

The motion of the Reference Committee to commend Dr. O. Frank Agee, Vice Chairman of the Committee on Continuing Medical Education in charge of annual meetings scientific programs and Dr. E. Eddy Burns, Chairman, Scientific Exhibits, be commended for their outstanding work in coordinating the scientific program and scientific exhibits carried.

The Reference Committee noted that the AMA's first free-standing winter scientific sessions will be held at Miami Beach in December 1977.

The motion of the Reference Committee that Dr. Michael J. Pickering be recognized for his outstanding contributions to Continuing Medical Education carried.

The motion of the Reference Committee that Dr. Yank Coble be commended for his vital contributions to the Committee on Continuing Medical Education during the past year carried.

The motion of the Reference Committee to adopt the Report of the Council on Scientific Activities carried.

Council on Scientific Activities

J. Lee Dockery, Chairman

Increased program activity within the areas of its three component committees made it necessary for the Council on Scientific Activities to meet three times during the Association's 1975-76 year. Meetings were conducted in Gainesville on September 19 and in Jacksonville on January 23. Action by the Council on business considered at those meetings is included in this report. The Council was to meet again in Gainesville on March 6, and activities of significance occurring then will be reported to the House in a supplemental report.

The year's activities are summarized below under the heading of the appropriate committee or of "Other Business."

I. — Committee on Medical Education

The Committee on Medical Education, chaired by Dr. J. Donald Wargo of Boca Raton, met in West Palm Beach on September 7, 1975, and in Tampa on January 17, 1976. This Committee has been especially active in reviewing legislation affecting the three medical schools, in creating better dialogue between and among the advisory committees of the medical schools, and in developing FMA seminars for medical students.

1. **Medical School Advisory Committees.** — All three medical schools have input into the Committee on Medical Education through their deans and through the chairmen of their medical advisory committees. In order that two-way communications may be enhanced, the Chairman and Vice-Chairman have made themselves available to attend the meetings of all three advisory committees.

The Committee has suggested, and the Council on Scientific Activities has concurred, that the minutes of all its meetings be furnished to members of the advisory committees.

Perhaps most important, the Committee on Medical Education is sponsoring a joint meeting of the medical advisory committees on Wednesday morning, May 5, at the Annual Meeting of the FMA at the Diplomat Hotel in Hollywood. The program will include a discussion of the role of the medical advisory committee by the three chairmen. The Committee has invited the President of the Association, Dr. Vernon B. Astler, to speak on the general theme of how each medical school can maintain its individuality and continue to relate well to organized medicine, the legislature, and other institutions.

2. **University of Miami Program.** — The Committee has developed a day-long seminar entitled "Private Medical Practice—The Facts of Life" for third- and fourth-year medical students, interns and residents. This program will be presented for the first time on April 10, 1976, at the University of Miami School of Medicine.

Program content includes discussion, by various FMA



Reference Committee I heard testimony and reported on business in the area of health and education. Left to right: Charles F. Tate, M.D., Miami; Dick L. Van Eldik, M.D., Lake Worth; Thomas E. McKell, M.D., Tampa, Chairman; Ms. Marcia Protheroe, Recorder; O. Frank Agee, M.D., Gainesville; and Robert N. Webster, M.D., Tallahassee. Coincidentally, all members of the Committee are either the Immediate Past President, incumbent President, or President-Elect of their county medical societies.

experts of such subjects as establishing a medical practice, medical ethics, the Medical Practice Act and other laws affecting medical practice, hospital staff relationships, continuing medical education, Blue Cross and Blue Shield, Medicare, Medicaid, Workmen's Compensation, other third-party programs, professional liability insurance, etc.

The Committee regrets that the available time is so short for discussion of such complex subjects. However, it is hoped that each speaker will be able to give the students at least a broad overview of the problems associated with each subject area.

When the program is presented at the University of South Florida and the University of Florida, it will probably be divided into six sessions of one and one-half hours each. Dates have not been established.

3. **Fifth Pathway.** — The so-called "Fifth Pathway" to licensure of American citizens enrolled in foreign medical schools has been a matter of continuing concern to both the Committee and the Council. Both groups have recommended that FMA reiterate its position that the Fifth Pathway is not in the best interest of the people of the State of Florida at this time.

Information has been received that the University of Miami School of Medicine has under consideration the admission of some of these students to the third-year class. It is felt that some American students can be trained to be acceptable physicians if they are brought back into the American educational system earlier than contemplated by the "Fifth Pathway" mechanism. The Committee and Council recognize this mechanism provided the students selected have credentials comparable to those of domestic school students, and provided further that implementation of this type of transfer program be the distinct prerogative of each individual medical school.

4. **Physician Manpower.** — The Committee was asked for its opinion on an American Medical Association report calling for expansion of existing medical school classes and construction of more medical schools as short-term and long-range means of providing more physicians. It is the belief of the Committee that Florida, has a population growth that includes a great influx or in-migration of physicians, which is not typical of most of the remainder of the country. The judgement of the Committee is that our three medical schools are turning out physicians in maximum numbers for their capability at this time, and, if properly funded, will continue to do so.

5. **Florida Board of Regents.** — At its second meeting, the Committee had a most cordial and informative dialogue with Mr. Jack McGriff, Chairman of the Health Affairs Committee of the Board of Regents. Mr. McGriff stated that he welcomed the advice of the Committee on matters pertaining to the two state medical schools, and for its part, the Committee is delighted to have this liaison with the Board of Regents.

6. **Community Hospital Education Council.** — The Committee has been interested in the program of the Community Hosptial Education Council (CHEC), whose mission is, in essence, to encourage the production of more primary care physicians for Florida. Two representatives of CHEC visited the Committee on January 17 to report on the status of the program.

The CHEC representatives are concerned that (1) the first graduates of the internship and residency programs they support are not remaining in Florida in as great numbers as they had hoped, and (2) many physicians currently in CHEC-supported programs are from other states.

It is the opinion of the Committee that CHEC's concern about statistics is sincere but that once the appropriate level of quality is reached in these training programs, many of which are relatively new, the retention statistics will be improved.

On this theme, however, the Council and Committee have recommended THAT FMA EXPAND ANY STUDIES IT MAY HAVE UNDERWAY AIMED AT CORRECTION OF THE PROBLEM OF MALDISTRIBUTION OF PRIMARY CARE PHYSICIANS.

7. **Legislation.** — The Committee anticipates that many bills affecting our medical schools will be introduced during the 1976 session of the Florida Legislature. Arrangements were to be made through the FMA Capital Office for quick referral of these bills to the Committee so that its input THROUGH THE APPROPRIATE FMA CHANNELS might be more timely and effective.

The Committee has reviewed prefiled bills relating to the training of physician assistants and creation of centers for diabetes education, treatment and research at the three medical schools; and has made appropriate recommendations as to the suggested FMA position on each.

8. **University of South Florida College of Medicine.** — Dean Donn L. Smith, M.D., has advised the Committee that the University of South Florida College of Medicine now enjoys full accreditation. The class size is 74, and the administration is awaiting the "fiscal opportunity" to expand to 96 per class. The College is endeavoring to create more general internists by cutting back on subspecialty fellowship programs.

9. **University of Florida College of Medicine.** — The class size at the University of Florida has been increased to 120, with the first class of that size to be graduated in two years. At the beginning of the year, the chairs of the departments of medicine and of microbiology were vacant, but the College was confident these vacancies would be filled in a short time. The College needs money to build additional support facilities at Shands Teaching Hospital.

10. **University of Miami School of Medicine.** — The University of Miami School of Medicine has been under considerable pressure to accept some "Fifth Pathway" students. The Committee and Council have recognized an alternate approach to this problem, i.e., to enroll certain qualified American students at foreign medical schools at the third-year level in a Florida medical school (see Paragraph 3, above).

11. **Program in Medical Science (PIMS).** — The Program in Medical Science (PIMS) at Florida State University and Florida A & M University in Tallahassee trains rural and minority students for matriculation at the University of Florida College of Medicine. About 60% of the PIMS students come from a 20-county area of the Florida Panhandle, South Georgia, South Alabama, etc. The Program's five-year federal grant, which provided about two-thirds of the budget, expires this year, making it necessary to convert to full state funding. Eighteen students have been accepted to begin training next fall, but due to fiscal uncertainty, the remaining 15 class positions will be uncommitted until funding is resolved.

II. — Committee on Scientific Publications

The Scientific Council is proud of the many improvements made over the past year in **The Journal of the Florida Medical Association** (JFMA). The Editor-Chairman Gerold L. Schiebler, M.D., and his entire Committee on Scientific Publications, are to be commended for the fine work, dedication and enthusiasm that has gone into the publication of the Journal.

1. **Graphics and Typography.** — The Committee has instituted a number of changes in the physical appearance of JFMA to make it more attractive to the reader. Efforts have been made to relate the cover of each issue to the lead article of interest. Three physicians with artistic talents have contributed cover drawings.

Beginning with the January 1976 issue, new face types were used for the first time, and the columns were widened. New "running heads" were designed to signal departmental features.

2. **Scientific and Editorial Content.** — The JFMA has endeavored to establish a standard of excellence for its scientific and editorial content. Each scientific manuscript submitted for publication is sent to seven or eight reviewers, each of whom is an FMA member or someone outside the profession who possesses expertise in the subject of the article under review. This practice of multiple referral tends to assure scientific soundness and involves more physicians in the day-to-day affairs of JFMA. Acceptance of a manu-

script for publication as presented is unusual. Some papers are rejected and many others are returned to the authors for rewriting or for minor change. Some of the more cogent comments of reviewers have been published as "editorial comment" at the end of several scientific articles.

The monthly "Dean's Page," which was suspended in 1974 because of budgetary reasons, has been reinstated. A monthly "Legislative News" page has been added, and the Book Review Section has been expanded with Assistant Editor F. Norman Vickers, M.D., assuming additional duties as Book Review Editor. A monthly summary of news of interest to Florida physicians, written by the Editor, is making its debut.

JFMA proposes to publish more Auxiliary news, particularly what has been contained in the past in the Auxiliary newsletter "The Beeper." The Committee has forwarded through the appropriate channels a recommendation that an Auxiliary Section be included in four issues per year which would be mailed to Auxiliary members' homes on a pro rata cost per subscription basis.

3. **Special Issues.** — Probably the most ambitious project undertaken by JFMA in recent years has been the Special Dermatology Issue, published in January 1976, in cooperation with the Florida Society of Dermatology. This issue was many months in preparation. Many accolades have been received on this issue.

A Special Issue on Snakebite was published in March. Other special issues on Neurosurgery, the 20th anniversary of University of Miami School of Medicine and Poisonous Plants in Florida are in the planning stages. The traditional historical issue will be published in August.

4. **Finances.** — JFMA has managed to function well within the fiscal guidelines outlined by the Executive Committee and Board of Governors. Printing costs have remained stable all through 1975 and so far this year, but increased FMA membership has driven the monthly printing costs up because of increased circulation. Postage rates have increased.

Advertising revenue is generally stable, largely as a result of a substantial rate increase imposed by JFMA as of July 1, 1975. JFMA hopes to tap additional advertising sources in a cooperative project with the **Florida Bar Journal.** The staffs of the two journals have had preliminary discussions directed toward a joint effort to attract several types of businesses that have not used either periodical in their advertising programs. Examples include bank corporations, automobile manufacturers and dealers, hotels, airlines, etc. The two journals plan to obtain the services of a publisher's representative to solicit these accounts.

5. **Consulting Editors.** — The present Editor is continuing a practice started several years ago of appointing a member of each FMA-recognized specialty group to serve as a Consulting Editor. Consulting Editors are asked to review manuscripts submitted for publication involving their specialties. The Consulting Editors were invited to the January meeting of the Committee, and many attended.

6. **County Society Bulletin Editors.** — Eight component medical societies publish monthly bulletins, and the Committee has established closer relationships with their editors. The county editors were invited to one meeting of the Committee, and four attended. The Committee has voted to appoint these county editors as Consulting Editors of JFMA.

III. — Committee on Continuing Medical Education

One of the busiest committees within the FMA for the past year has been the Committee on Continuing Medical Education, functioning under the chairmanship of Yank D. Coble Jr., M.D., of Jacksonville. The Committee has faced many challenges with implementation of the Association's continuing medical education program, it's accreditation activities, and the supervision of the planning of the Scientific Program for the Annual Meeting.

The Committee has met four times: June 5, 1975, in Orlando; July 26, 1975, at Ponte Vedra Beach; October 31, 1975, in Sarasota; and January 29, 1976, in Orlando. Its activities will be discussed in this report.

1. **FMA Continuing Medical Education Program for Members.** — December 31, 1976, marks the end of the first three-year cycle in the Association's mandatory continuing medical education program for members. There have been many problems associated with this program, and the Committee has endeavored to resolve them as much as possible. Some of these problems have included a general lack of understanding of requirements by FMA members; inability of many county medical societies to handle record-keeping functions, which may be due in part to lack of funds; and confusion of the provisions of the FMA program with those of American Academy of Family Physicians program and the American Medical Association's Physician's Recognition Award program.

On February 1, the House of Delegates, in interim session at Orlando and acting upon the recommendation of both the Committee and the Scientific Council, modified the FMA program. Prior to the modification, the program required FMA members to earn 90 hours of continuing education credit, including a minimum of 60 hours in the "mandatory" category, during each three-year cycle. The amendment enacted this year enables members to meet the CME membership requirements in any one of the following ways:

a. Obtaining the AMA Physician's Recognition Award within three years.
b. Completing, over a three-year cycle, 150 hours of continuing medical education credits of which a minimum of 60 hours shall be mandatory hours as defined and described by the Florida Medical Association.
c. Being certified by the American Academy of Family Physicians as having obtained 150 hours of credit over a three-year period.

The Chairman of the Committee submitted alternate plans for transition from the "old" to the "new" program to the Executive Committee at its meeting on February 11, 1976. The Executive Committee deferred action until the March meeting of the Board of Governors, which presumably will discuss the subject appropriately in its report to the House of Delegates.

During the year, the Committee found it necessary to suggest amendments to "Procedures Governing the Postgraduate Education Program Adopted by the FMA Board of Governors, October 1974." These changes were approved by the Board of Governors at its meeting in October 1975.

2. **Accreditation Activities.** — Another important sphere of the Committee's activity has been the CME accreditation program. During the year, the Committee accredited the educational activities of the Sarasota County Medical Society following visitation by a survey team. This enables the Society to sponsor AMA Category 1 activities.

Under the rules of the AMA, the Committee cannot itself sponsor the Annual Meeting Scientific Program and other educational offerings of the Florida Medical Association for AMA Category 1 credit. In the past, the Committee has been forced to secure the co-sponsorship of one or more of the State's three medical schools in order to qualify these programs for Category 1. However, the Committee has been working through the Board of Governors to have an acceptable accreditation entity established within the Florida Medical Foundation to sponsor and co-sponsor programs for AMA Category 1 credit.

3. **Central Registry.** — A central registry of medical education courses and seminars offered in Florida is maintained in the FMA Headquarters under the auspices of the Committee. From 1974 to February 1976, the registry contained information on 1060 such programs, including 172 that are presented on a continuing (weekly or monthly, etc.) basis.

Another aspect of the CME program is individual course approval. Approximately 300 applications for such approval are referred to the Subcommittee on Program Approval each year. The disapproval rate is less than 10%.

4. **Florida Compact for Continuing Medical Education of Physicians.** — When this program was conceived, medical and surgical specialty societies, county medical societies,

and other entities offering medical education programs were invited to become participants. The basic aim is to coordinate the educational efforts of the signatories and avoid scheduling conflicts. The program is under revision and a Subcommittee has been created to work on this project.

IV. — Subcommittee on Annual Meeting Program

The Subcommittee on Annual Meeting Program, chaired by O. Frank Agee, M.D., of Gainesville, is a component of the Committee on Continuing Medical Education. The Subcommittee is to be commended for its early completion of the 1976 Annual Meeting Scientific Program.

For the second consecutive year, the program was published in virtual entirety in the February issue of JFMA. Specialty societies are joining with the FMA in sponsorship of 30 scientific sections, Wednesday through Saturday of the Annual Meeting. In addition, two drug companies are offering programs for which physicians may receive CME credit.

By careful scheduling of meeting attendance, the physician may earn a full year's quota of 20 "mandatory" hours at the 102nd Annual Meeting of FMA.

Physicians attending the meeting should find the scientific and educational exhibit particularly interesting and useful this year. The number of applications for exhibit space overflowed the Exhibit Hall, and additional space had to be found to accommodate several good exhibits that otherwise might have been turned down.

V.—Other Business

1. **Research Grant Applications.** — The Council reviewed three applications for Florida Medical Foundation Research Grants and recommended two of them for funding. These are:

 a. Application 75-1—"Screening for Hypertension in a Population of College Students at the University of Florida Student Health Infirmary," George A. Richard, M.D., of Gainesville ($7,830).
 b. Application 75-2—"Electromyographic Studies of Patients with Scoliosis," Robert W. Bright, M.D., of Gainesville ($4,372).

2. **AMA Curriculum Committee.** — The American Medical Association's first free-standing winter scientific sessions will be held at Miami Beach in December 1977. FMA has appointed, at the request of AMA, a Curriculum Committee chaired by the Chairman of the Council on Scientific Activities and including several members of the FMA Committees on Medical Education and Continuing Medical Education. This group will work closely over the next several months with the AMA Council on Scientific Assembly.

3. **Michael J. Pickering, M.D.** — The Council on Scientific Activities wishes the House to give proper recognition to Michael J. Pickering, M.D., who retired as Chairman of the Committee on Continuing Medical Education. Dr. Pickering provided untiring leadership as the Committee implemented the FMA continuing medical education program.

Recommendation

That Dr. Michael J. Pickering be recognized for his outstanding contributions to continuing medical education.

Supplemental Report
Council on Scientific Activities

The Committee requested that Dr. Coble, CME Chairman, be called upon to explain the new revised policy in regard to the three initial reporting cycle dates for reporting continuing medical education activities. Dr. Coble's remarks were received with interest and appreciation by the House.

The motion of the Reference Committee to approve the Supplemental Report of the Council on Scientific Activities carried.

Supplemental Report
Council on Scientific Activities
J. Lee Dockery, Chairman

This report is presented for the information of the House of Delegates on recent activities of the Council on Scientific Activities.

1. **Committee on Continuing Medical Education**

As noted in the Report of the Council on Scientific Activities (House of Delegates Handbook, page I-6), the House of Delegates at its recent Interim Meeting adopted a Continuing Medical Education Policy which offered options for fulfilling the requirements similar to the former policy, but increased the hours for the FMA Program beginning January 1, 1976, to 150 hours within three years.

At the invitation of the Executive Committee, the Committee on Continuing Medical Education and the Council on Scientific Activities considered recommendations for effecting the transition between the 1973 Continuing Medical Education Policy and the 1976 revisions. The resulting **Policy Interpretation** and **Procedures** were presented to the Board of Governors at its March 20, 1976, meeting.

Under the revised policy, a member has a choice of three initial reporting cycle dates: 1) 1974-1975-1976; 2) 1975-1976-1977; 3) 1976-1977-1978. Therefore, all present FMA members should complete at least one three-year cycle by December 31, 1978. A new member should begin the initial three-year CME cycle the January 1 after becoming a member. Cycles subsequent to initial cycles are to begin the January 1 after the completion date of the previous cycle. The one-year "grace" period for reporting activities was retained for all cycles.

Members electing initial Cycle 1 or Cycle 2 under the FMA Program need complete a total of only 90 hours within three years, identical to the former FMA requirements. Starting January 1, 1976 (Cycle 3 and all subsequent cycles), members must complete the 150-hour requirement, with a minimum of 60 of these hours being from courses approved by the FMA, designated AMA "Category 1" by AMA-accredited institutions or "Prescribed" by the American Academy of Family Physicians.

In its continuing efforts to communicate with county medical societies, the Committee has already sent an informative mailing to county medical society officers, executive staffs, and continuing medical education chairmen. Moreover, each specialty society president and secretary have been informed of the new **Policy Interpretation** and **Procedures.** They were further requested to reaffirm their society's commitment to the FMA Program and to submit appropriate continuing medical education criteria for approval if they have not already done so.

Currently, revised CME Reporting Forms and explanatory material are being sent to each FMA member. In this mailing is included a postal card on which every member will choose initial cycle dates and method of fulfilling requirements. Thus, when this information is collated, FMA headquarters can supply each county medical society with a list of members' choices, as well as a list of those members not responding. This latter group can then be contacted while there is still sufficient time to participate in continuing medical education activities before the reporting deadline in 1978.

2. **1977 AMA Mid-Winter Scientific Session**

Nine FMA members have accepted appointment to the "working" FMA Subcommittee to the AMA Curriculum Committee for the 1977 AMA Mid-Winter Scientific Session to be held in Florida. All have been active in the areas of medical education and/or continuing medical education. Members of this subcommittee are: J. Lee Dockery, M.D., Chairman,

Gainesville; Yank D. Coble Jr., M.D., Jacksonville; O. Frank Agee, M.D., Gainesville; Henry M. Yonge, M.D., Pensacola; Bernard J. Fogel, M.D., Miami; Jere W. Annis, M.D., Lakeland; Donn L. Smith, M.D., Tampa; William T. Mixson, M.D., Coral Gables; Michael J. Pickering, M.D., Tampa (Alternate).

3. **Fifth Pathway**

Members of the Committee on Medical Education and deans of the three medical schools and/or their representatives met in Miami on Sunday, April 11, with State Senator Jack Gordon to discuss the problem of the "Fifth Pathway." The deans agreed to admit at third-year level certain bona fide Florida residents who are qualified and who are presently enrolled at a foreign medical school, particularly the Autonomous University of Guadalajara, Mexico. The agreement reached between the deans and Senator Gordon is included in the delegates' packets as an informational item.

Council on Specialty Medicine

The motion of the Reference Committee to replace the word "Licensure" on Page I-12, Line 30, with the word "Certification" was adopted.

The motion of the Reference Committee to defer the portion of the report, consideration of "Medicaid Payment for Pap Smears," until later in the report carried.

The motion of the Reference Committee to adopt the Report of the Council on Specialty Medicine as amended, with the exception of the portion which was deferred, carried.

Council on Specialty Medicine

Frederick C. Andrews, Chairman

The Council on Specialty Medicine held three meetings during the Association year 1975-76: on September 19, 1975 in Orlando, December 13, 1975 in Orlando and February 21, 1976 also in Orlando. A special committee of the Council on the Florida Relative Value Studies met once on February 21, 1976.

The Council is currently comprised of 35 FMA-recognized specialty groups, and two applications for recognition are pending.

Attendance at all meetings has been excellent. The Chairman is grateful for the interest and active participation by members and alternates and also many specialty group officers in the deliberations of the Council.

The Council has considered a large number of matters affecting medicine, and the following is a summary of the general activities of the Council throughout the year. All recommendations of the Council have been submitted to and acted upon by the Board of Governors and are included in the Board of Governor's Report to the House of Delegates.

HOUSE OF DELEGATES REFERRALS

Statement of Policy Regarding Legislative Coordination—The House of Delegates at its meeting in April, 1975 referred the Statement of Policy Regarding Legislative Coordination back to the Board for clarification. The Council has reviewed the policy statement and submitted recommended amendments to the Board to clarify the policy statement.

Treatment and Diagnosis of Mental & Emotional Disorders—The House of Delegates at its meeting in April, 1975 referred Recommendation No. 14, Treatment and Diagnosis of Mental and Emotional Disorders to the Board of Governors for clarification. The Council has recommended to the Board of Governors that no agency of the State be permitted to hire non-physicians (psychologists or social workers) to practice medicine as defined in the statutes of the Medical Practice Law FS 458 for the diagnosis and treatment of mental or emotional disorders.*

OTHER ACTIONS

Legislation—The Council has endeavored to encourage specialty groups to coordinate their legislative activities with the FMA. Each specialty group has been requested to establish a liaison committee with the FMA Committee on State Legislation and has encouraged FMA when possible to provide specialty groups legislative services to include, circulation of the **FMA Legislative Bulletin,** copies of bills of major interest, analysis of major bills, and coordination of lobbying activities.

The Council noted with appreciation the significant and continued efforts of the Committee on State Legislation and particularly its past Chairman, Dr. George H. Evans, Tallahassee, who regrettably moved from the State. The Council has recommended to the Board of Governors that Dr. Evans be formally commended by FMA through the appropriate award.

Professional Liability Insurance—The Council expressed its support of the proposals for professional liability reforms as outlined in the position paper submitted by FMA President Dr. Vernon B. Astler to the Professional Liability Insurance Commission. The Council commends the FMA for its efforts in seeking to ensure the availability of professional liability insurance coverage and the development of a well designed insurance trust for its members. The Council was also greatly appreciative of the informative and knowledgeable presentation made by Dr. James W. Walker, President of PIMCO, to the Council regarding the administration of the FMA-PLI-Trust.

Florida State Hospital at Chattahoochee—At the request of the Florida State Division of Mental Health, the Florida Chapter of the Council of District Branches of the American Psychiatric Association conducted an investigation of alleged abuses in prescribing medication, lack of doctor-patient contacts and side-effects to psychotropic drugs in the forensic unit at Florida State Hospital in Chattahoochee. Upon hearing the report of the findings of the investigation, the Council concurred with the findings that the alleged abuses appeared to be without basis.

Biofeedback—Considerable discussion and study regarding the establishment of biofeedback as a medical procedure rather than solely a psychiatric treatment of psychosomatic diseases have been undertaken by the Council on Specialty Medicine. The Council on Medical Economics has reviewed the procedure as to payment by third parties. The Florida Council of District Branches of the APA recommended to the Council that the FMA should refrain from entering the role of approving or disapproving medical practices or procedures and reaffirm that any procedure used in diagnosis or treatment of illness should be reimbursed by insurance companies as long as the procedure is part of a recognized medical treatment plan. The Council has expressed its feeling to the Board of Governors that the FMA should express approval or disapproval of such practices and procedures and requested the Florida Council of District Branches of the APA to submit pertinent information to the Council regarding biofeedback in order that specific recommendations can be made.

Yellow Page Directory Listings—Upon referral from the Board of Governors, the Council reaffirmed support of the actions of the 1974 FMA House of Delegates action regarding telephone directory listings that only AMA-recognized and approved specialty and subspecialty listings be used for telephone directory listings. (This item was pre-empted by action of the House of Delegates, Feb. 1, 1976).

Termination of Pregnancy and Experimentation on the Fetus—The Council reviewed legislation (HB 1160) that has been prefiled for consideration by the 1976 legislative session which would requlre written certification by two physicians before termination of pregnancy after the 24th week of pregnancy and expressed its opposition to such legislation in that it contained no cut-off point and was in effect up until the full term of a pregnancy. Due to the

*The Board of Governors recommended that this be amended to request that no state agency hire non-physicians to practice medicine as defined in the Medical Practice Law FS 458—See Board of Governors Report.

legislation's vague terminology, the Council opposed proposed legislation (SB 60) which dealt with medical procedures used in the termination of pregnancy and experimentation on a live fetus.

Relative Value Studies—Upon request of the Council, the Board of Governors deferred final approval of the 1975 Relative Value Studies until January, 1976 in order to allow a reasonable amount of time for review and recommendations by the specialty groups.

For some time the Council has been concerned about the input specialty groups have in the development of the Relative Value Studies. As a result, the Council Chairman appointed a Subcommittee within the Council to assess the current methods used in the preparation of the RVS. The Council endorsed the Subcommittee's recommendations and has submitted to the Board of Governors for consideration recommendations for improving the procedures used in development of the Relative Value Studies. The Council acknowledged the many long hours of hard work by the FMA Committee on Relative Value Studies, but feels that specialty groups should play a more active role in the development of future Relative Value Studies.

Medicare Part B-Maximum Allowance Roll Back—The Council urged the Board of Governors to use whatever means available to seek a reversal of the ruling of the Social Security Administration regarding Medicare Part B which placed limitations on the maximum prevailing level of payment to physicians and beneficiaries.

Nurse Practitioners/Nurse Assistants—The Council expressed opposition to procedures being performed by registered nurses which are not covered in the Nurse Practice Act and recommended that the State Board of Medical Examiners be advised of FMA's opposition to a nurse practitioner or nurse assistant performing any such acts and that they not be allowed to bill for third party payments.

Mandatory Uterine Cytologic Examinations—The Council expressed opposition to legislation (HB 2367) prefiled for consideration by the 1976 session of the Legislature which would require mandatory uterine cytologic examinations. The Council expressed support for a voluntary uterine cytology program as seen appropriate by each hospital medical staff.

Emergency Medical Technicians—The Council supported and endorsed legislation for certification testing of EMT-II's and requiring physician supervision and monitoring of those advanced life support components of the EMS system that would require a physician to be responsible for supervision of EMT-II's through direct contact or by standing written orders.

Physician Population Ratios for Medical Specialties—The Council recognizes the need for specific recommendations in the area of physician population ratios for medical specialties, and the Chairman has appointed a Committee within the Council to study this matter and make recommendations.

Florida Society of Ophthalmology—The Council expressed its support for the Florida Society of Ophthalmology in its efforts to overturn a policy decision of the Florida State Board of Optometry allowing the use of drugs for diagnosis and treatment by optometrists in Florida and noted that this policy decision had been advanced without due process. The Council also supported the protest of the Florida Society of Ophthalmology to the Joint Administrative Procedures Commission that proper hearings and reviews were not carried out prior to the implementation of this policy.

Nuclear Medicine Technologists—The Council reviewed information presented regarding the problem areas faced by nuclear medicine technologists in Florida who meet national standards for licensure but do not meet the criteria established under the Florida Clinical Laboratories Act. The Council supported the proper identification of nuclear medicine technologists, either through certification under the Clinical Laboratory Law or through separate legislation.

Criteria for Recognition of Specialty Groups—In reviewing applications of specialty groups for recognition by the FMA, the Council expressed its concern over the continuing increase in the size of the Council and the overlap of specialty representation. The Chairman has appointed a Subcommittee within the Council to review the criteria for recognition and make recommendations to the Board of Governors for possible revisions.

Medicaid Payment for Pap Smears—[Referred to Board of Governors—R.C.I] The Council reviewed the non-payment of routine pap smears by the Medicaid Program and has recommended to the Board of Governors that all government medical care programs and third parties, including Blue Shield, consider pap smears as a necessary medical procedure and provide reimbursement to physicians for this procedure.

Telecommunications and Data Processing Systems—The House of Delegates at its meeting in 1975 approved and endorsed the AMA pilot program of data collection, and each specialty group has been working in this area. The Council received a report regarding the work done during the year in developing procedures with CPT and CMIT.

The Council expressed its endorsement in furthering this program by developing an organization within the medical profession comprised of specialty society members, establishing policy for approval and supervision of data processing systems, standardizing coding and processing methods, and continuing its liaison with medical care insurers.

Licensure of EKG Technologists—The Council reviewed proposed legislation regarding licensure of EKG Technologists by the State Board of Medical Examiners and has recommended opposition to the licensure of EKG technologists by the State Board of Medical Examiners due to the increased cost of medical care with would result and the questions which would arise as to who would supervise these individuals.

Vision & Blood Pressure Requirements-School Bus Drivers—The Council reviewed requests from the State Department of Safety and Motor Vehicles as to vision acuity requirements and acceptable levels of blood pressure for school bus drivers. The Council has recommended to the Board of Governors that the vision acuity requirements for school bus drivers be acceptable at 20-40 or better in each eye with corrective lenses if necessary, and acceptable levels of blood pressure as a maximum of systolic pressure of 180 or a minimum of 90 and a maximum of diastolic pressure of 105 or a minimum of 40.*

Florida Chapter of The American Academy of Pediatrics and the Florida Pediatric Society—The Council expressed its congratulations to the Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society for the honor received from The American Academy at its annual meeting in November, 1975 as the nation's outstanding pediatric group for 1975 for a comprehensive improvement program in Florida resulting in "one of the best systems" of child care in America.

Abortions and Eugenic Sterilizations of the Mentally Retarded—The Council reviewed information regarding eugenic sterilization of the mentally retarded and recommended that the FMA give strong consideration to proposing to the Florida Legislature enabling legislation that would permit, under well defined boundaries, eugenic sterilizations where such a procedure is indicated.

Report of Board of Governors

Resolution 75-20

Use of Florida Mental Health Hospital Facilities

The motion of the Reference Committee to approve the continuing efforts of the FMA to reject the

*The Board recommended that the State Department of Safety and Motor Vehicles consult with its medical advisory committee regarding acceptable levels for blood pressure and vision acuity requirements—See Board of Governors Report.

housing of criminals in mental institutions and the Board of Governors Report on Resolution 75-20 carried. (See Report of Board of Governors, Page 510.)

CME Programs

The motion of the Reference Committee that the Board's Report on the CME Programs be approved as printed in the Handbook carried. (See Report of Board of Governors, Page 517.)

Physicians Assistants

The motion of the Reference Committee that the Physicians Assistants portion of the Board Report be approved as printed in the Handbook carried. (See Report of Board of Governors, Page 517.)

Community Hospital Education Program

The motion of the Reference Committee to approve the Board's Report on the Community Hospital Education Program carried. (See Report of Board of Governors, Page 517.)

Fifth Pathway

Recommendation No. 15

The motion of the Reference Committee to adopt two substitute recommendations to replace Board of Governors Recommendation No. 15 carried. (See Report of Board of Governors, Page 517.)

Continuing Medical Education

The motion of the Reference Committee to approve the Board's report on Continuing Medical Education carried. (See Report of Board of Governors, Page 517.)

Specialty Group Recognition

The motion of the Reference Committee to approve the Board's report on Specialty Group Recognition carried. (See Report of Board of Governors, Page 517.)

Nurse Practitioners

Recommendation No. 16

The motion of the Reference Committee to approve the Board's Recommendation No. 16 on Nurse Practitioners carried. (See Report of Board of Governors, Page 517.)

Florida Society of Ophthalmology

The motion of the Reference Committee to approve the Board's Report on the Florida Society of Ophthalmology carried. (See Report of Board of Governors, Page 517.)

Payment of PAP Smears

Recommendation No. 17

Council on Specialty Medicine

Medicaid Payment for PAP Smears

The motion of the Reference Committee to refer back to the Board of Governors for consideration by the appropriate Council and for specific recommendations in regard to PAP Smears and other screening and diagnostic procedures carried. (See Report of Board of Governors, Page 517.)

Florida Society of Colon and Rectal Surgeons

The motion of the Reference Committee to approve the Board's report on the Florida Society of Colon and Rectal Surgeons as printed in the Handbook carried. (See Report of Board of Governors, Page 518.)

Resolution 76-2

CME Credit—National Specialty Societies

Broward County Medical Society

The Reference Committee advised this Resolution was not considered as no representative appeared before the Committee to sponsor it.

Resolution 76-7

Fourth Florida Medical School

Lee County Medical Society

The Reference Committee moved that Resolution 76-7 be disapproved. The motion carried, and Resolution 76-7 was disapproved.

Resolution 76-18

The School of Medicine of the Uniformed Services University of the Health Sciences

Sarasota County Medical Society

The motion by the Reference Committee that Resolution 76-18 be disapproved carried. Resolution 76-18 was disapproved.

Resolution No. 76-24

Primary Care

Charles K. Donegan, M.D., Delegate

The Reference Committee moved that Resolution 76-24 be disapproved. The motion carried, and Resolution 76-24 was disapproved.

Upon motion duly carried, the report of Reference Committee No. 1 as amended was adopted.



The Camera Visits . . .

Top Row: The retiring Auxiliary President, Mrs. C. Brooks Henderson (right) turns over the gavel to Mrs. William H. Harrison . . . Dr. and Mrs. H. Phillip Hampton of Tampa . . . Drs. Daniel B. Nunn and Sanford A. Mullen of Jacksonville.

Second Row: Dr. and Mrs. John Glotfelty of Lakeland . . . Mrs. Vernon B. Astler of Boynton Beach . . . Mrs. Edward R. Morrow and Dr. Clyde M. Collins of Jacksonville, and Dr. Jack A. MaCris of St. Petersburg . . . Dr. and Mrs. James W. Walker of Jacksonvile . . . Dr. Joseph G. Matthews of Orlando . . . Blue Cross-Blue Shield President Jack Herbert and Dr. Emmet F. Ferguson of Jacksonville and Dr. William B. Deal of Gainesville . . . Dr. Charles K. Donegan of St. Petersburg and Mrs. Jack A. MaCris.

Third Row: Dr. James T. Cook of Marianna . . . Dr. J. Lee Dockery of Gainesville and Dr. Thad Moseley of Jacksonville . . . Dr. and Mrs. James L. Borland, Jr., of Jacksonville . . . Dr. Leo M. Wachtel, Jr., of Jacksonville and Mrs. William Elsner of Orange Park . . . Mrs. C. Brooks Henderson and Dr. Henderson of Ocala and Dr. W. Dean Steward of Marianna



. . . The 102nd Annual Meeting

. . . Mrs. C. Brooks Henderson and Dr. Betty Siegel . . . Mrs. Burns A. Dobbins of Ft. Lauderdale and Dr. and Mrs. William J. Dean of St. Petersburg. . . .FMA Executive Vice President W. Harold Parham and Dr. and Mrs. John G. Elmquist of West Palm Beach. Dr. and Mrs. Burns A. Dobbins of Ft. Lauderdale . . . Dr. Ralph Cranwshaw, guest speaker from Portland, Ore.

Fourth Row: FMA Executive Vice President W. Harold Parham . . . Committee on Scientific Publications and wives: Dr. William B. Straight of Miami, Dr. and Mrs. A. Lee Messer of St. Petersburg, Mrs. J. Lee Dockery of Gainesville, Dr. E. Charlton Prather of Tallahassee, Mrs. Louise Rader, Dr. Dockery, Mrs. F. Norman Vickers of Pensacola, Dr. Vickers, Mrs. Gerold L. Schiebler of Gainesville and Dr. Schiebler. . . .Dr. and Mrs. Don C. Smallwood of Delray Beach. . . .Dr. and Mrs. Vernon B. Astler of Boynton Beach, Mrs. Jack A. McCris of St. Petersburg, Dr. MaCris, and Mrs. C. Brooks Henderson of Ocala and Dr. Henderson . . . Dr. and Mrs. W. H. Matthews of Jacksonville . . . Dr. George S. Palmer of Tallahassee and Dr. Jack A. MaCris of St. Petersburg . . . Dr. William J. Dean of St. Petersburg and Dr. and Mrs. Eugene G. Peek of Ocala.

Report of Reference Committee No. II

Public Policy

The Vice Speaker assumed the Chair and called for the report of Reference Committee No. II.

Dr. Gerold L. Schiebler, Chairman, and his committee came forward to present the report of Reference Committee No. II, Public Policy.

Council on Medical Services

The motion of the Reference Committee to approve the Report of the Council on Medical Services as printed in the Handbook carried.

Council on Medical Services

J. Russell Forlaw, Chairman

During this reporting period, all of the committees under the Council on Medical Services have been very active. Many of these committees provide advice on a continuing basis to governmental agencies, legislative committees, and various other organizations.

The following consolidated report will commence with a brief summary of the Chairman's on-site evaluation report of the medical facilities at the Lake Butler Prison Reception Center and will be followed by the descriptions of each committee's major activities.

Florida's Prison Medical Facilities—On February 24, Dr. J. Russell Forlaw made an on-site evaluation tour of the medical facilities at the Lake Butler Prison Reception Center located in Lake Butler, Florida. Every inmate who enters the Florida Prison System is first routed through this complex for testing and orientation.

During this visit, Dr. Forlaw interviewed the Prison Medical Director, Hospital Administrator, and Nursing Director. Also, a tour was made of the entire medical facility. The overall impression received was a fairly high level of medical care with certain limitations such as: (1) shortage of personnel (2) low wages (3) inadequate space (4) severe shortage of lab equipment.

Other factors discussed included philosophical considerations as to what level of medical care society should provide prison inmates. The institution doctors all felt that prison inmates should receive the same level of care as other patients on the outside.

All of the medical staff seem to have a personal vested interest in the prison hospital, and each person seemed willing to give extra effort in spite of the admitted shortages. Following this visit, the Council on Medical Services recommended that the FMA establish on a continuing basis some form of liaison with the prison medical staff.

The Committee on School Health continues to play a vital role as the Medical Advisory Committee to the Department of Education and to the Health Program Office, Department of Health and Rehabilitative Services. During the past year, several special county health education projects were reviewed to determine their relationship with Florida's Comprehensive Health Education Program.

Recommendations were made concerning state and federal legislation involving school health. Considerable attention was also given to the administration of medication in public schools, confidentiality of student records, training for teachers in nutrition education, physical examination forms for student athletics, injuries from trampolines used in physical education programs, recognition programs for student fitness awards. The Committee went on record as supporting the Education for Parenthood Project.

Committee on Drug Abuse—The Committee on Drug Abuse has devoted all of its time to the completion of the contract between the Florida Medical Foundation and the Department of Health and Rehabilitative Services for an on-site evaluation study of the medical care being received at twenty-nine (29) residential drug abuse treatment centers.

Acting as Steering Committee for this contract, the Committee met on three occasions. At the present time, fourteen (14) of the residential drug abuse treatment centers have been evaluated, and the remaining programs will be evaluated by June 1, 1976. The Steering Committee will make its final report by June 30, 1976.



Reference Committee II studied public policy matters: Left to right: Ms. Patti Davis, Recorder; Gerold L. Schiebler, M.D., Gainesville, Chairman; Joseph H. Davis, M.D., Miami; Calvin W. Martin, M.D., Arcadia; Francis C. Coleman, M.D., Tampa; and Alan Holcomb, M.D., Orlando.

Committee on Public Health—The Committee on Public Health has reviewed and made recommendations concerning the reorganization of the Department of HRS, minimum standards for home care agencies, a proposed organization to promote clean air in Florida, and continues to provide advice on legislative matters.

Committee on Rural Health—The Committee on Rural Health studied the problems dealing with availability of health care for Florida's rural citizens and made several recommendations concerning this subject. One recommendation that received Board approval allows FMA sponsorship of a "Physician Recruitment Conference." The purpose of the conference is to inform medically underserved communities on the problems associated with setting up medical practices in these areas and will suggest ways that the communities might attract physicians.

The Committee continues to represent the FMA on the Florida Committee on Rural Health, which includes representatives from major organizations in the State.

The Committee on Emergency Medical Services was one of the most active this year. Considerable attention was given to the subject dealing with physician supervision of advanced life-support treatment, such as carried out by EMT II's. Special conferences were recommended to gather expertise for the purpose of planning EMS public education programs and to propose an acceptable plan for categorization of critical care facilities.

The Committee also made recommendations concerning state legislation, commercial EMS medical information services, and problems dealing with emergency communications.

Supplemental Report
Council on Medical Services

The Reference Committee moved a substitute for the Recommendation in the Supplemental Report on Council on Medical Services. A motion from the floor to amend the substitute carried.

The motion to adopt the Supplemental Report of the Council on Medical Services, as amended, carried.

Supplemental Report
Council on Medical Services

During recent weeks the federal government has proposed, with the approval of President Ford, a massive vaccination program to prevent a possible epidemic of influenza next year. This proposal was based on recommendations by the President's Advisory Committee on Immunization, as well as representatives from the Center for Disease Control, the World Health Organization and others. The strain of influenza which the program is aimed at preventing is a newly identified swine virus which represents a major change from viruses which are currently circulating in the human population. The new strain of human influenza virus designated A/New Jersey/76 (H swlN1) was first isolated in an outbreak of respiratory disease among recruits in training in Fort Dix, New Jersey.

Influenza swine virus is known to be antigenically stable as compared to other influenza strains which have commonly caused disease in humans. This same or similar strain of swine virus is felt to be responsible for the pandemic of influenza of 1918.

At national and state levels, organized medicine has pledged its complete cooperation. Florida, the first preliminary planning meeting was held in Tallahassee on April 27, 1976, and the Florida Medical Association was represented by William R. Stinger, M.D., Chairman of the Committee on Public Health.

Many unresolved issues and variables exist such as the vaccine production and delivery, manpower, equipment and supplies, liability considerations, site selection, records, etc. Hopefully, these matters will be addressed as systematically as possible by the joint efforts of the private and public sectors.

Although it is unfortunate that most of the planning and implementation details are so sketchy at this time, some facts seem evident. First, the assistance of private physicians, nurses, and other volunteers will be needed at mass immunization clinics. Health departments simply do not have sufficient personnel to handle the anticipated public response. Second, as many physicians as possible should offer the vaccine to patients in their private offices and clinics. Health departments will provide free vaccine and it is assumed that physicians may charge for the administration of it. One issue that has already emerged, is whether or not state and/or county medical societies should recommend standard, reasonable fee for service.

Recommendation

a) That the Florida Medical Association strongly support the national swine influenza vaccination program;

b) That each county medical society be requested to designate a committee to coordinate its members participation in this program, with emphasis on mass immunizations in the physician's office.

Report of Board of Governors
Resolution 75-18
Inhalation Therapy

The motion of the Reference Committee to approve the Board's report on Inhalation Therapy as printed in the Handbook carried. (See Report of Board of Governors, Page 510.)

Nurse Practice Act

The motion of the Reference Committee to adopt the Board's report on the Nurse Practice Act as printed in the Handbook carried. (See Report of Board of Governors, Page 510.)

Recommendation No. 2
Diagnosis and Treatment of Mental or Emotional Disorders
(1975 Recommendation No. 14)

The motion of the Reference Committee to adopt the Board's report and Recommendation No. 2 regarding Diagnosis and Treatment of Mental or Emotional Disorders as printed in the Handbook was adopted. (See Report of Board of Governors, Page 510.)

U.S. Congress—Rural Health Week

The Reference Committee congratulated the Board of Governors and Dr. Forlaw, Chairman of the Council, for initiating this innovative and vital program designed to aid Florida's citizens.

The motion of the Reference Committee to approve the Board's report on the U.S. Congress-Rural Health Week as printed in the Handbook carried. (See Report of Board of Governors, Page 513.)

Physician Recruitment Conference

The motion of the Reference Committee to approve the Board's report on the Physician Recruitment Conference as printed in the Handbook carried. (See Report of Board of Governors, Page 515.)

Recommendation No. 8
State Task Force on Rural Health

The Reference Committee revised Recommendation No. 8 of the Board's report regarding State Task Force on Rural Health and the motion to adopt the Board's Recommendation No. 8 as revised carried. (See Report of the Board of Governors, Page 515.)

Primary Care Physicians

The Reference Committee noted the Board's commendation of the Board of Regents for their current and continued emphasis on primary care, and revised the report to include in the commendation the Community Hospital Education Council, for its role in enhancing educational environments designated to provide physicians interested in primary care.

The motion of the Reference Committee to approve the Board's Report on Primary Care Physicians as revised carried. (See Report of the Board of Governors, Page 515.)

EMS Legislation

The motion of the Reference Committee to approve the Board's report on EMS Legislation as printed in the Handbook carried. (See Report of the Board of Governors, Page 515.)

Additional State Funding for County Health Departments

Upon recommendation of the Reference Committee the Board of Governors' report on additional state funding for county health departments was changed by replacing the word "client" to "patient." This was noted as an editorial change.

The motion of the Reference Committee to approve the Board's report on additional state funding for county health departments with the noted editorial change carried. (See Report of Board of Governors, Page 515.)

Recommendation No. 9
Minimum Standards for Home Health Agencies

The motion of the Reference Committee to approve the Board's recommendation for Minimum Standards for Home Health Agencies as printed in the Handbook, be approved, carried. (See Report of Board of Governors, Page 515.)

Recommendation No. 10
Public Education

The Reference Committee revised Section I of Recommendation No. 10 to include "physicians," and reworded Section II.

The motion of the Reference Committee to adopt the Board's Recommendation No. 10 on Public Education as revised carried. (See Report of the Board of Governors, Page 515.)

Conference on EMS Public Education

The Reference Committee commended the Board of Governors for its vision in co-sponsoring the Conference on Emergency Medical Services Public Education through the Florida Medical Foundation, and moved to approve the report as printed in the Handbook. The motion carried. (See Report of the Board of Governors, page 516.)

Recommendation No. 11
Categorization of Critical Care Facilities

The Reference Committee moved that the Board's Recommendation No. 11, Categorization of Critical Care Facilities, be approved as printed in the Handbook.

A motion from the floor to amend the Recommendation by deleting from the "Resolved" of the Recommendation the words "as a catalyst for development of systems" and substituting the words "to determine hospital capabilities" carried. Recommendation No. 11 was adopted as amended. (See Report of the Board of Governors, page 516.)

Recommendation No. 12
Physician Supervision of
Advanced Life-Support Techniques

The motion of the Reference Committee to adopt the Board's Recommendation No. 12 on Physician Supervision of Advanced Life-Support Techniques with an amendment deleting from the last paragraph the words "and accept responsibility for the medical performance for," carried. (See Report of the Board of Governors, Page 516.)

Recommendation No. 13
Commercial Medical Information Service

The motion of the Reference Committee to adopt the Board's Recommendation No. 13 on Commercial Medical Information Service as printed in the Handbook carried. (See Report of Board of Governors, Page 516.)

Committee on Voluntary Health Agencies

The motion of the Reference Committee to approve the Board's report of the Committee on Voluntary Health Agencies as printed in the Handbook carried. (See Report of Board of Governors, Page 518.)

Report of
Committee on Allied Health Professions

The motion of the Reference Committee to approve the Report of the Committee on Allied Health Professions as printed in the Handbook carried.

Committee on
Allied Health Professions

Gerald D. N. Bryant, Chairman

The Committee on Allied Health Professions continues to provide liaison with the following health professions:

1. Florida Dental Association
2. American Association of Medical Assistants
3. Florida Dietetic Association
4. Florida Society of Medical Technologists
5. Florida Nurses Association
6. Florida Association of Dispensing Opticians
7. Florida Pharmaceutical Association
8. Florida Chapter, American Physical Therapy Association
9. Florida Podiatry Association
10. Florida Society of Radiologic Technologists
11. Florida Veterinary Medical Association

Presently, the Committee is considering a request for formal recognition from several other allied health professions. These groups have been asked to respond to certain criteria before recognition is given.

Rules and regulations for the new Nurse Practice Act are being considered by an Advisory Committee to the State Board of Nursing. This Advisory Committee consists of three members of the Board of Medical Examiners and three members of the State Board of Nursing. Public hearings on these rules and regulations will be held in May, 1976. The FMA Committee on Allied Health Professions plans to have representation at these hearings.

On October 7, 1965, the Chairman met with representatives of the Florida Pharmaceutical Association to discuss legislation involving drug substitution and multi-line prescription forms. During these discussions, possible alternatives were suggested in an effort to avoid needless legislation. Recommendations have been made to the Board of Governors concerning these subjects.

Supplemental Report
Committee on Allied Health Professions

The Reference Committee recommended an amendment in the Committee's Recommendation, to insert "when desirable and feasible" after "invite".

The motion of the Reference Committee to adopt the Supplemental Report of the Committee on Allied Health Professions, as altered, carried.

Supplemental Report
Committee on Allied Health Professions

On March 28, 1976, there was a meeting of the FMA Committee on Allied Health Professions and the attendants included representatives from the various Allied Health Professions. During this meeting, there was considerable discussion dealing with pre-filed health legislation, and there was agreement that the health field, in general, needs to be united if it is to be successful in the legislative arena.

Several Allied Health Profession representatives pointed out that there had been many disagreements among the professions which seemed to have occurred through a lack of communication and understanding. In an effort to improve communication between the FMA and Allied Health Professions, the Committee will increase the number of future joint meetings.

Recommendation

THE COMMITTEE ON ALLIED HEALTH PROFESSIONS RECOMMENDS THAT **THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION** PERIODICALLY INVITE, WHEN DESIRABLE AND FEASIBLE, "GUESTS EDITORIALS" FROM OFFICIAL REPRESENTATIVES OF ALLIED HEALTH PROFESSIONS.

Committee on Voluntary Health Agencies

The motion of the Reference Committee to adopt the report of the Committee on Voluntary Health Agencies as printed in the Handbook carried.

Committee on
Voluntary Health Agencies

Robert C. Palmer, Jr., Chairman

The Committee on Voluntary Health Agencies is completing the review of applications for the 1976-77 FMA Recognition Program. This Committee has recommended renewal of FMA recognition for twelve (12) Voluntary Health Agencies:

1. Arthritis Foundation, Florida Chapter
2. American Cancer Society, Inc., Florida Chapter
3. Florida Heart Association
4. Florida Coordinating Council, National Kidney Foundation
5. Easter Seal Society

6. Florida Association for Retarded Citizens
7. Florida Epilepsy Foundation, Inc.
8. Florida Lung Association
9. Leukemia Society of America, Florida Division
10. Mental Health Association of Florida
11. National Foundation—March of Dimes
12. National Multiple Sclerosis Society

Renewal applications have not been received from the United Cerebral Palsy of Florida, Florida Society for the Prevention of Blindness, and the Muscular Dystrophy Association, Florida District. However, at the request of these three agencies, the Committee has extended the application deadline in order that these agencies will have additional time to apply for recognition in 1976-77.

On February 20, 1976, the Committee met with most of the recognized agencies and discussed state regulations that Voluntary Health Agencies operate under. The agencies pointed out how inflation continues to increase the cost of raising funds that their programs so desperately need.

The Reference Committee commended the Board of Governors; the distinguished President, Dr. Vernon B. Astler; Dr. W. Harold Parham, Executive Vice President, and the involved FMA staff for their superb conduct of the affairs of the Association during the past year, noting that the items referred were characterized by lucidity and reflected careful consideration of many complex matters.

Resolution 76-15
Podiatrists' Hospital Staff Membership
Capital Medical Society

After consultation with representatives of the Capital Medical Society, Orange County Medical Society and Dr. Francis T. Holland, Chairman of the Florida Delegation to the AMA, a substitute for resolution 76-15 was submitted by the Reference Committee.

The Reference Committee moved to adopt Substitute Resolution 76-15 and the motion carried.

Substitute Resolution 76-15
Podiatrists' Hospital Staff Membership

RESOLVED, that the FMA and AMA House of Delegates request the Joint Commission on Accreditation of Hospitals (JCAH) to make no recommendation on hospital staff membership for Podiatrists and other Allied Health Professionals and leave this matter to individual hospital staffs.

The motion of the Reference Committee to adopt the Report of Reference Committee No. II on Public Policy as amended carried.



House Speaker Louis C. Murray, M.D., (center) presides at a session of the House of Delegates. Others left to right: Secretary James W. Walker, M.D.; President Vernon B. Astler, M.D.; Executive Vice President W. Harold Parham, D.H.A.; Dr. Murray; Vice Speaker Charles Kahn, M.D.; President-Elect Jack A. MaCris, M.D.; Vice President Irving Essrig, M.D.; and Immediate Past President Thad Moseley, M.D.

Report of Reference Committee No. III
Finance and Administration

The Speaker called for the report of Reference Committee III, Finance and Administration. Dr. Richard M. Fleming, Chairman of the Committee, was unable to be present and Dr. Charles K. Donegan presented the report for Dr. Fleming.

Report of Board of Governors

The motion of the Reference Committee to adopt Recommendation No. I, Legislative Coordination, carried.

The motion of the Reference Committee to adopt Recommendation No. 4, California Medical Society Resolution re Use of Social Security Numbers, carried.

The motion that a copy of this Resolution including all supporting data be sent to each of the state medical associations and the AMA carried.

The motion of the Reference Committee to adopt Recommendation No. 5, Amendment to the Medical Practice Act, carried.

The Reference Committee reported that Recommendation No. 19, Amendments to the By-laws, evoked considerable discussion.

Clarification of the By-Laws

At the present time, our By-Laws Chapter 1, Membership, Section 1, Qualifications and Eligibility, Item 1, states "Any doctor of medicine may be accepted into membership in the Florida Medical Association, Inc. upon certification by the secretary of his component society that he is a member in good standing of that society, provided such certification is accompanied by remittance of all required fees, dues, assessments and an archives data form."

The Florida State Board of Medical Examiners requires that the applicant must have had at least one year of internship or residency training in an AMA approved program before he can be licensed. The Osteopathic Board has no such requirement. The Reference Committee, therefore suggested that Chapter 1, Section 1, Item 1 of the By-Laws be retained intact.

The Reference Committee inserted an additional item, stating "Any doctor of osteopathy who has satisfactorily completed an AMA approved internship and/or residency training program may be accepted into membership in the Florida Medical Association, Inc. upon certification by the secretary of his Florida Medical Association component society that he is a member in good standing of that society, provided such certification is accompanied by remittance of all required fees, dues, assessments and an archives data form."

The motion of the Reference Committee to adopt Recommendation No. 19, with the clarifications listed, carried.

The motion of the Reference Committee to ap-



Finance and administration were Reference Committee III's area of concern. Left to right: Charles K. Donegan, M.D., St. Petersburg; Richard M. Fleming, M.D., Miami, Chairman; Ms. Cindy Jones, Recorder; O. William Davenport, M.D., Miami; and Yank D. Coble, Jr., M.D., Jacksonville.

prove the Report of the Board of Governors as amended with the exception of those items referred to the other reference committees, carried.

Report of
Board of Governors
Vernon B. Astler, President

Your Board of Governors has held 6 meetings during the past Association Year 1975-76. The Board met in regular session on April 27, 1975, October 9-11, 1975, January 18, 1976, February 1, 1976 and March 20-21, 1976. There was one called meeting of the Board on August 9, 1975.

During this past year medicine has continued its pursuit of providing quality care to the citizens of our state and preservation of the high standards and ethics of our profession in the face of great adversities. We have struggled against spiraling increases in the cost of professional liability insurance which has eaten away at our ability to provide quality medical care at reasonable costs. We have seen the very welfare of our patients jeopardized and the application of the advances in medical science threatened because of a social fever which manifests itself as the malpractice crisis.

We have faced yet another year of the incessant interference and control of our practices and our personal lives by government. We have seen social and health planners develop master plans that would make health care delivery little more than a public utility.

The crisis which physicians face in our state and across our nation demand strength of wisdom and character to prevail. We have this year been joyed by our victories, saddened by our losses, and above all we have been honored by never having been shamed by not trying.

The single greatest asset this Association has is the physicians who give of their time and talents in activities of the Association, and your Board is grateful to each and everyone. Your Chairman is deeply honored for having had the opportunity of serving this fine organization and for the privilege of associating with those who served on the Board this year. Each one has represented his fellow physicians to the best of his ability and has given unselfishly of his time and talents. Your Chairman wishes to thank each of them: Jack A. MaCris, Thad Moseley, James Walker, Thomas Thames, Irving Essrig, Richard Dever, Francis Holland, Joseph Von Thron, Louis Murray, Eugene Peek, Jr., Benjamin Cole, Joseph Matthews, Curtis Cannon, Theodore Marshall, Richard Hodes, and Donald Nikolaus.

Major Activities

Your Board has spent over 100 hours in formal session to review the activities of councils and committees and many other matters of primary concern to medicine. The following is a summary of the major activities and actions of the Board in its deliberations, and its recommendations to the House of Delegates.

1976 Annual Meeting—The Board approved the format for the 1976 Annual Meeting and noted with pleasure the continuing improvement in the quality of the scientific program and the promptness with which the program is prepared. Dr. J. Lee Dockery and Dr. O. Frank Agee (and the members of the Committee on Scientific Programs) were commended for their efforts in this regard.

1976 Interim Meeting and Leadership Conference—The House of Delegates at its meeting in April, 1975 referred Resolutions 75-27 and 75-30 regarding interim meetings of the House of Delegates to the Board for consideration. It was the feeling of the Board that an Interim Meeting of the House should be held in lieu of the FMA Leadership Conference in January, 1976 and that the agenda be limited to the legislative program and only other business items deemed necessary by the Board. The format as approved for the Interim Meeting included:

1. 1976 FMA PLI Legislative Program
2. Continuing Medical Education
3. Specialty group listings in the telephone directory yellow pages
4. A special assessment for PLI legislative and public relations activities.

The general session on Saturday included a presentation by U.S. Congressman Robert H. Michel of Illinois and a panel discussion on professional liability legislation. There was a Flampac Workshop held in conjunction with the Interim Meeting.

Financial Statement and Budget—The Board reviewed the financial statement prepared by the Executive Vice President and approved the auditors' statement presented by the Treasurer, prepared by Lucas, Herndon, Hyers, & Pennywitt, Certified Public Accountants. This audit report which covered the calendar year 1975, showed Association income from all sources was $1,346,630.96 and total expenses during the year were $1,097,865.57. This was an excess of $248,765.39 in income over expenditures and reflects the dues increase which became effective January 1, 1976. These figures do not include funds expended for equipment and interest paid as these are carried under the fixed assets of the Association. The Board approved a budget for 1976 totaling $1,332,000 which is anticipated income from all sources. In compliance with the By-laws, the budget was prepared by the Executive Vice President in consultation with the Treasurer.

Headquarters Building and Capital Office—An additional 4,200 sq. ft. of office space was added to the FMA Headquarters Building and was completed in Nov. 1974. The Board has approved the purchase and renovation of an office building in Tallahassee to house the FMA Capital office staff. The single story building which includes approximately 3,000 sq. ft. of office space is strategically located just one block from the Capital. It is expected that the building will be ready for occupancy in late mid-April. This $120,000 expenditure will be paid for by the FMA's interest in Harlan-Med, Inc.'s liquidation distribution and not from Association reserves.

Appointments—The Board of Governors approved the nomination of Francis T. Holland, M.D. as the AMA Delegate to serve on the Board of Governors. Thomas B. Thames, M.D., Orlando, was appointed as optional member of the Executive Committee.

Appointed as advisory members of the Board of Governors were Eugene G. Peek, Jr., M.D., Department of Health and Rehabilitative Services; Joseph G. Matthews, M.D., Blue Shield of Florida, Inc.; Benjamin M. Cole, M.D., Florida State Board of Medical Examiners; and Louis C. Murray, M.D., Speaker of the House of Delegates. Joseph C. Von Thron, M.D., was designated as Public Relations Officer and was designated as the Board's representative to Flampac.

In January, 1976, Gerold L. Schiebler, M.D., was reappointed to serve as Editor of **The Journal of the Florida Medical Association for 1976-77.** William M. Straight, M.D. was appointed FMA Historian and Historical Editor of **The Journal** and Richard C. Dever, M.D. was designated as the Board of Governors representative on the Scientific Publications Committee.

Appointed as Chairmen of Committees of the Board were:

Committee on Allied Health Professions
Gerald Bryant, M.D.
Committee on Voluntary Health Agencies
Robert C. Palmer Jr., M.D.
Committee on County Medical Society Presidents
Harold L. Williamson, M.D.
Committee on Press, Radio & TV Relations
Robert E. Windom, M.D.

Francis T. Holland, M.D. and Burns A. Dobbins, Jr., M.D. were reelected Chairman and Vice-Chairman respec-

tively of the FMA Delegates to the American Medical Association.

Awards

A. H. Robins Award—The Board reviewed nominations received from county medical societies and selected the recipient of the A. H. Robins Company Award "For Outstanding Community Service by a Physician." This award will be presented at the First Meeting of the House of Delegates' on May 5, 1976. The recipient for this year's award is included in the Delegates' Packets.

Distinguished Layman's Award—The House of Delegates in 1972 established a Distinguished Layman's Award. The purpose of the award is to recognize individuals who have made significant and lasting contributions to the medical profession. The House directed the Board to develop the criteria for establishing the award and further that the Board would select the recipient.

The Board has selected Florida's U.S. Congressman Paul G. Rogers of West Palm Beach as the 1976 recipient of the Distinguished Layman's Award. The appropriate citation, along with criteria, is included in the Delegates' Packets for information.

Nominations

Certificate of Merit and Certificate of Appreciation—The Board is pleased to nominate to the House of Delegates a distinguished physician to receive the Certificate of Merit (the Association's highest honor of achievement), and two physicians to receive the Certificate of Appreciation. These nominations are included in the Delegates' Packets for presentation at the First Meeting of the House of Delegates.

Judicial Council—In compliance with the FMA By-laws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1976 and to fill an unexpired term created by the resignation of Dr. William Straight.

The Board nominates Dr. Vincent Corso and Dr. Paul Harding to the House of Delegates for election to the Judicial Council at-large for a five-year term; and Joseph Davis, M.D., Miami, for election to the Judicial Council for Medical District D to fill the unexpired term created by the resignation of Dr. William Straight.

Committee on Membership and Discipline—In compliance with the By-laws, the Board has reviewed terms expiring in 1976 on the Committee on Membership and Discipline. Nominations from county medical societies have been considered and the Board nominates the following physicians for election to the Committee on Membership and Discipline for the terms indicated:

District 1
W. Howard Cooper, III, M.D. (80)
District 2
James Cook, M.D. (80)
District 3
John A. Rush, Jr., M.D. (80)
District 4
Charles C. Barrineau, M.D. (80)
District 5
Frederick C. Andrews, M.D. (80)
District 6
John T. Karaphillis, M.D. (80)
District 7
William B. Hopkins, Jr., M.D. (80)
District 8
T. M. Caswall, M.D. (80)
District 9
Clarence Gilbert, M.D. (80)
District 10
Peter Rosier, M.D. (80)
District 11
Ray E. Murphy, Jr., M.D. (80)
District 12
Anthony J. Vento, M.D. (80)
District 13
Arthur W. Wood, Jr., M.D. (80)
Maurice Laszlo, M.D. (77)
District 14
Rufus K. Broadaway, M.D. (80)
District 15
Norman M. Kenyon, M.D. (80)

Blue Shield Board of Directors—The Board selected nominees for election to the Blue Shield Board of Directors from a list of names submitted by the Blue Shield Nominating Committee. Nominees for each physician seat were selected as follows:

Medical District B—One Vacancy—Three Year Term
Irving Essrig, M.D., Tampa
Frank J. Fischer, M.D., Winter Haven
Medical District D—One Vacancy—Three Year Term
Walter C. Jones, III, M.D., Coral Gables
Daniel Seckinger, M.D., Miami
At-Large—Three Vacancies—Three Year Term
(1) Billy Brashear, M.D., Gainesville
John D. Corbitt, M.D., Lake Worth
(2) John N. Carlson, M.D., Sarasota
Herbert E. Brooks, M.D., Bonifay
(3) J. Champneys Taylor, M.D., Jacksonville
Stephen Z. Schilder, M.D., Ft. Walton Beach

Lay members nominated by the Nominating Committee and approved by the Board are:

Medical District D—One Vacancy—Three Year Term
Thomas S. Trantham, Jr., Miami
At-Large—One Vacancy—Three Year Term
Wallace Mathes, Sarasota
At-Large—One Vacancy—Three Year Term
Louis A. Doman, Pensacola
Hospital Administrator/Blue Cross Board Member—One Vacancy—One Year Term
Robert T. Besserer, Sanford

Florida State Board of Medical Examiners—In compliance with the House of Delegates' policy, the Board of Governors taking into consideration recommendations by component medical societies, compiled a list of physicians which was forwarded to Governor Reubin Askew for his consideration in making appointments to the Florida State Board of Medical Examiners.

AMA Councils and Committees—The Board was pleased to submit nominations for reappointment to AMA Councils and Committees.

Referrals by House of Delegates

The 1975 Proceedings of the House of Delegates were reviewed and items requiring additional study and action were referred to the appropriate councils and committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council reports as well as in this report.

Community Hospital Education Council—The House of Delegates approved a recommendation that a physician be appointed by FMA to serve as liaison with the Community Hospital Educational Council.

Legislative Coordination—The House of Delegates referred the Policy Statement developed by the Council on Specialty Medicine regarding coordination of legislative activities of specialty groups to the Board of Governors for clarification of paragraph 3 of the statement. This has been reviewed by the Council on Specialty Medicine and clarification submitted to the Board.

RECOMMENDATION NO. 1

That the following statement of policy regarding coordination of legislative activities of specialty groups be adopted:

Statement of Policy

1. It is essential for the FMA to develop a program of legislative activity that will provide the necessary and appropriate role for FMA recognized medical specialty groups in their relationships with the legislature.
2. Periodically FMA recognized medical specialty groups will have interests and concerns that are specific to them and not necessarily of major interest and concern to the FMA as a whole.
3. Those specialty groups with particular interests and concerns should have the privilege of developing legislative programs of their own, providing that these programs are not in conflict with the FMA policy and provided that these programs are coordinated with the Chairman of the Council on Legislation and Regulations. (Approved R.C. III)

Resolution 75-18-Inhalation Therapy—This resolution was not adopted but referred to the Board of Governors for study by the Committee on Allied Health Professions. The resolve of this resolution called for contacting the Inhalation Therapy Society and communicate concern and assist in drafting legislation to assist in correcting problem areas.

The Florida Society for Respiratory Therapy was contacted by the Committee on Allied Health Professions in reference to this matter. The Committee has received complete cooperation from the Respiratory Therapy Society and is presently studying a written report submitted by their society. This report concerns their recommendations on what is necessary for sufficient regulation of the inhalation therapy industry.

On March 28, 1976, representatives of the Committee on Allied Health Professions and the Florida Society for Respiratory Therapy will formally meet for further discussion on this subject. (Approved R.C. II)

Nurse Practice Act—The House of Delegates instructed the Board of Governors to monitor legislation during the 1975 session of the Legislature to modify the Nurse Practice Act.

Part of this legislation established an Advisory Committee to the State Board of Nursing for the purpose of writing the rules and regulations regarding this Act. The Advisory Committee consists of three members of the Board of Medical Examiners and three members of the State Board of Nursing.

The Committee on Allied Health Professions has monitored the meetings of the Advisory Committee and is currently studying the first draft of the rules and regulations for the New Nurse Practice Act.

Public hearings will be held in different locations in the state in May, 1976. These hearings will concern the first draft and rules and regulations for the new Act. The Committee on Allied Health Professions plans to have physician representatives at each of these hearings. (Approved R.C. II)

Resolution 75-20—Use of Florida Mental Health Hospital Facilities—This resolution was not adopted, but referred to the Board of Governors for study and appropriate action. The resolve of this resolution calls for FMA to reject the housing of criminals in the same facility as the mentally ill. (Approved R.C. I)

This matter has been under review by the Council on Specialty Medicine through the Florida Council of District Branches of the American Psychiatric Association and the South Florida Psychiatric Society. A resolution has been submitted to the Department of HRS regarding the establishment of prisons on the grounds of Florida State mental hospitals, which urged that the plan to establish a prison on the grounds the G. Pierce Wood Memorial Hospital be abandoned; that no new prisons be established on the grounds of state hospitals; and that the River Junction Prison at Chattahoochee be deactivated as soon as feasible. Construction had begun for the prison facility at G. Pierce Wood Memorial Hospital, however, a court injunction had been entered against the Department from completing the facility. The River Junction Prison at Chattahoochee has been operational since 1974 and currently has approximately 400 inmates.

Substitute Resolution 75-22—This resolution calls for separation of the offices of FMA Secretary and Treasurer to provide wider geographical representation on the Board and the development of an effective communications network between FMA and component county medical societies. The separation of the offices of Secretary and Treasurer have been effected and elections were held during the 1975 meeting of the House of Delegates. Included in this report are recommended amendments to the FMA By-laws to provide for membership of the Treasurer on the Executive Committee.

The Association has endeavored to develop a more effective method of communications with component societies. Information is transmitted through the FMA Briefs, President's Memorandums, the **FMA Journal, Legislative** Bulletin and the EVP Gray Paper. In addition, periodic meetings have been held with officers and executive staff of county medical societies to keep them informed of FMA activities. Dr. Astler also appointed a special Committee on Press, Radio and TV Relations to coordinate activities of FMA and county medical societies in communications with the news media in all matters pertaining to medicine.

A comprehensive package of material regarding the 1976 FMA Professional Liability Legislative Program has been distributed to all county medical society presidents, executive directors, legislative chairmen and other appropriate key contact physicians. In addition, a special professional liability legislative newsletter will be implemented during the legislative session. Additional communication methods are being developed for implementation in the immediate future.

Privilege of the Floor—The House of Delegates directed the Board of Governors to formulate a change in the By-laws to extend Privilege of the Floor to general officers of the AMA who are members of the FMA. Recommended amendments to the By-laws to effect this provision are included in this report to the House.

Recommendation No. 14 (In the Board Report to the 1975 House of Delegates)—Diagnosis and Treatment of Mental or Emotional Disorders—This Recommendation was not adopted, but referred to the Board of Governors for further study. The resolve seeks to ensure continuance by the Department of Vocational Rehabilitation in using only physicians in the diagnosis and treatment of mental or emotional disorders.

This recommendation was referred to the Council on Specialty Medicine for study, and the Board at its meeting in March reviewed the recommendation of the Council.

RECOMMENDATION NO. 2

That the FMA requests that no agency of the state hire non-physicians (psychologists or social workers) to practice medicine as defined in the Medical Practice Law for the Diagnosis and Treatment of Mental or Emotional Disorders. (Approved R. C. II)

Resolution 75-4-Osteopaths-FMA Membership—This resolution adopted by the 1975 House of Delegates directed the Board to submit amendments to the By-laws to the House to allow county medical societies to accept as members osteopaths deemed qualified. Proposed amendments to the By-laws to effect this provision are included in this report to the House. Guidelines for acceptance of qualified osteopaths as members are included in the Judicial Council's report to the House of Delegates.

Resolution 75-27-Annual Meeting & Resolution 75-30-Legislative Session-House of Delegates—These resolutions were not adopted, but referred to the Board for consideration. The 1976 Interim Meeting has previously been outlined in the report. The Interim Meeting of the House of Delegates has been scheduled for January 28-30, 1977 in Orlando.

Resolution 75-29-Interns & Residents—This resolution adopted by the House of Delegates reduced dues for medical interns and full-time physicians in an approved residency or internship from $25.00 to $10.00 per year. Recommendations for amendments to the By-laws to effect this provision are included in this report to the House.

Health Planning Resources Development Act of 1974—The House of Delegates directed that the Board of Governors give this Act careful consideration and that the Council on Legislation and Regulations develop a plan of action to deal with this legislation. This has been under close scrutiny by the Council on Legislation and Regulations and the Council on Medical Systems. The activities of these two councils in this regard are presented in the Annual Report to the House of Delegates. (Approved R.C. IV)

Resolution 75-10-Release of Medical Records to Insurance Carriers—This resolution was not adopted but referred to the Board of Governors for in-depth study and implementation of a program to protect confidentiality of patients' records. The principles embodied in this resolution are under study by the Council on Medical Systems in its efforts to establish a mechanism by which medicine serves as a centralized manager of health data to ensure control of confidentiality by the private sector.

Resolution 75-9-Medicaid-Length-of-Stay Controls

Resolution 75-12-Medicare/Medicaid Certification Procedures

Resolution 75-19-Utilization Review Regulations

Resolution 75-21-Utilization Review Regulations—These resolutions were not adopted, but referred to the Board of Governors for consideration. Implementation of utilization review regulations governing hospital admissions of Medicare and Medicaid patients has been vigorously opposed by both FMA and AMA.

These regulations would have required that a hospital committee review the admission of all Medicare and Medicaid patients within one working day of admission to determine whether the admission was "medically necessary" according to pre-established written criteria and norms.

In a lawsuit filed on February 20, 1975, the AMA contended that these regulations constituted an unlawful interference with the rights of patients and physicians.

As a result of the AMA's lawsuit, Judge Julius J. Hoffman of the United States District Court for the Northern District of Illinois on May 27, 1975, issued a preliminary injunction against the challenged regulations. The preliminary injunction was affirmed on July 22, 1975, by the United States Court of Appeals for the Seventh Circuit.

The FMA has an established defense fund to assist members who have had spurious or unwarranted suits filed against them. These funds are available subject to recommendation of the local county medical society. These physicians have been awarded financial assistance in support of a countersuit against both claimant and attorney in nuisance suits. The FMA-PLI-Trust will also aggressively defend a physician member of the Trust against any unwarranted suit.

The Board is continuing study of this resolution and similar proposals.

Board Actions of Major Importance

FMIT Program-Psychiatric Benefits—The Board of Governors reported to the House of Delegates at its 1975 meeting that an extensive review of the FMIT program experiences had been made and that major medical coverage for nervous and mental disorders would again be included should a majority of the membership covered under the program wish to have them reinstated. As a result of a survey, the Board requested Blue Shield to reinstate the psychiatric benefits with the understanding that there will be adequate peer review by psychiatric peers.

The Committee on PMUR has noted its assignment by the Board of Governors to be responsible for reviewing psychiatric benefits under the FMIT Program and the Committee has developed the following guidelines to facilitate these reviews.

1. Blue Shield will allow payment of up to $1,000 (50%) out of the FMIT for psychiatric care after the original $300 deductible is deducted in total benefits of $2,300.
2. Further benefits will not be paid out until the treating physician has filled out a "Mental Health Report."
3. The Committee on PMUR will request from the Florida Psychiatric Society a list of members who would be willing to serve as consultants to the Committee on PMUR to review psychiatric benefits under the FMIT Program.
 A. These consultants will be responsible for reviewing the "Mental Health Reports."
 B. The consultants' recommendations will be reviewed by the Committee on PMUR. (Approved R.C. V)

PMUR—The Board approved renewal of the contract between the FMF and Blue Shield for peer review for the Medicare Program with physician reimbursement at $50.00 per hour. The Board also approved a contract for peer review with Group Health Inc. (GHI), the recently designated carrier for Medicare in Dade and Monroe Counties.

Seminar on Medical Directors in Skilled Nursing Homes—The Board approved FMA's co-sponsorship with the AMA a seminar on the role of the Medical Director in the Skilled Nursing Facility. The two-day seminar was held January 10-11, 1976 in Tampa and was highly successful with over 300 registrants. Among the many topics covered were Federal Regulations and Guidelines, the need for medical directors, major areas of concern in solving problems, and medical decisions without liability. The FMA Committee on Hospitals and Extended Care Facilities was commended for its role in planning and coordinating the seminar. (Approved R.C. V)

Professional Liability—The House of Delegates at its meeting in April, 1975 adopted Resolution 75-4 Public Liability Insurance:

> RESOLVED, That the FMA respectfully endorse current legislative package and apreciatively applauds its proponents in the Florida Legislature, and be it further
>
> RESOLVED, That the FMA looks forward to continuing legislative involvement and appropriate additional reforms as needed, and be it further
>
> RESOLVED, That the FMA, through its Board of Governors remains prepared to mobilize as needed, all meaningful resources to ensure the continuity of health care delivery to Floridians, and to that end, to ensure appropriate liability insurance coverage to the physicians of Florida.

Pursuant to the action of the House, the Board authorized the Executive Committee to pursue development of an appropriate professional liability insurance mechanism for implementation at the appropriate time, provided specific statutory relief is obtained.

Through the resources of the London Agency, Harlan of Texas, Marsh McLennan and Frank B. Hall an indepth search was made of the PLI market in the United States. Every major company was contacted. There was no stable or major company in the United States willing to underwrite the FMA program due to size (approximately $20 million-a-year premium). As a result the FMA-PLI-Trust has been

established under the laws of the State of Florida to provide professional liability coverage to the members of FMA.

Briefly, the Trust and its management company, Professional Management Company (PIMCO), will provide:

—$500,000 basic coverage, no aggregate (premium the same as January 1st, 1975 Argonaut premium for $100,000).

—Domestic and foreign markets are being explored for Umbrella coverage.

—Annual protection coverage (claims made) with automatic premium payment of endorsement for extended coverage (occurrence basis) for death, disability, or normal retirement. Other members are subject to an additional premium or to a surcharge.

—Members of the Trust will participate in the payment of up to a maximum of the damages arising out of claims against them (20%) of the damages up to the first $25,000.

—Forty percent of the first year premium will be placed in a security deposit account (in the physician's name) and if not needed for losses in 5 years may be returned with interest.

—All participants must be reviewed and recommended by their county medical society and the FMA to be eligible for membership in the Trust.

—Centralized claims handling and legal coordination will be afforded this program and there will be an active defense of every unwarranted claim.

—A risk management program will be established with adequate service offices in several geographical locations of Florida.

The decision of your Board to implement this Trust was one of the most difficult ever undertaken. Many long, hard hours were spent in deliberating the ramifications of whether or not to proceed, realizing full well that if the Trust failed, it could mean financial ruin to the Association. The Board felt it imperative to proceed, but that this was only a temporary form of relief and that effective remedial legislation should be pursued with great diligence.

The House of Delegates at its Interim Meeting in January approved a comprehensive Professional Liability Legislative Program for introduction in the 1976 session of the Legislature aimed at bringing relief to the malpractice dilemma. Pursuant to the actions of the House of Delegates the Board has approved priority objectives for professional liability legislation during the coming session as outlined in the Annual Report of the Council on Legislation and Regulations which is included in the Delegates' Handbook. These legislative objectives have been given equal priority and have been expanded on by the Board to provide greater emphasis on a statutory definition of negligence and the establishment of expert panels to be used in determining the amount of damages awarded in malpractice judgements. (Approved R.C. IV)

Contingency Fees—Your Board realizes the critical effect the current system of contingency has on professional liability and has given much thought as to the most effective means by which a limitation on contingency fees could be achieved. The Board directed that proper protocol be pursued in petitioning the Supreme Court regarding the regulation of contingency fees. FMA's petition seeks modification of the contingency fee proposal of the Florida Bar and contends that the amendment suggested by the Bar is far too high to bring about the improvements needed. (Approved R.C. IV)

Mediation Panels—One of the most potentially viable aspects of the PLI Omnibus bill passed by the 1975 Legislature is the provision for mandatory mediation of alleged malpractice claims. These panels have been declared unconstitutional by a number of circuit courts throughout the state and a ruling is pending before the State Supreme Court. The Board has authorized funds for legal counsel to present arguments before the Court in an effort to maintain these panels. (Approved R.C. IV)

Joint Underwriting Association—Board/Commission—The Board named William J. Dean, M.D., of St. Petersburg, as the FMA representative to serve on the JUA Board of Governors and Robert J. Brennan, M.D., of Ft. Lauderdale to serve as his alternate and submitted names of physicians to be considered for appointment to the JUA Study Commission to study and make recommendations for a medical liability insurance system for the State of Florida.

Special Assessment—The House of Delegates at its interim meeting in 1976 deliberated the urgent need for a statewide comprehensive public relations program in addition to an immediate dynamic legislative program to meet the continued professional liability crisis and a special assessment to finance it.

The House approved an assessment of $100.00 for 1976 for each regular active dues-paying member to be escrowed for public relations activities and implementation of the professional liability legislative goals approved by the House of Delegates.

The assessment is being billed directly by the FMA rather than through county medical societies. The assessment is not voluntary; therefore is tax deductible. At the writing of this report $465,700.00 has been received which represents 55.3% of this membership.

Utilization Review—The Board is of the opinion that it is not the obligation of the physicians to provide cost containment and medical care information to the U. S. Government. The Board directed that the Florida Physicians Association be advised of the action of the Board regarding utilization review regulations and furnishing cost containment and medical care information to the U. S. Government, and request their assistance in disseminating the information to the physicians of the State. (Approved R.C. V)

National Health Insurance—The Board reviewed testimony presented by FMA President Dr. Astler before a subcommittee regarding National Health Insurance and Florida's position. Dr. Astler's testimony was published in the February issue of the FMA Journal. (Approved R.C. V)

AAFMC—The Board was advised that the American Association of Foundation for Medical Care has been carrying on activities that are not in consort with FMA policy and has directed the FMF not to renew membership in the American Association of Foundations for Medical Care when the current membership expires.

AMA—Vice President—The Board of Governors enthusiastically endorsed the candidacy of Dr. Francis T. Holland of Tallahassee for Vice President of AMA.

FMA Medical Districts—The Board reviewed the membership in the state's four medical districts and the increases and decreases in membership where noted. The Board did not feel that it was necessary to consider redistricting at this time.

District	Membership January 1975	January 1976	Change
A	1,798	1,905	+107
B	2,432	2,579	+147
C	2,805	3,000	+195
D	2,832	2,900	+ 68

Medicaid-Physicians' Services—The Board was advised that as of January 1, 1976 program changes were made for services rendered in Florida's Medicaid Program, which resulted in a cutback in fees for specified procedures outlined by the Department of Health and Rehabilitative Services. The Board voiced strong opposition in a letter to the Governor and the Secretary of HRS to the cutback in fees for allowable charges for physicians' services under Florida's Medicaid Program, expressed its dismay at the mismanagement of the program and further stressed that this cutback will result in a further sharp reduction in the services available to Medicaid recipients. (Approved R.C. V)

Congressional Visitation Program—The Board voted to continue the Congressional Visitation Program for 1976, with emphasis on regular visits by individual key contact physicians with their assigned Congressmen in Washington.

Death With Dignity Legislation.—Referred to Board of Governors—R.C. IV] The Board reviewed correspondence

received from Dr. Walter Sackett requesting the Board to reconsider its former attitude that legislation is not necessary in the field of "Death With Dignity."

RECOMMENDATION NO. 3

That the FMA reaffirm the position adopted by the House of Delegates in 1974 that medical matters as the criteria of death or the time of death, or what constitutes death with dignity are the physicians' responsibility requiring professional judgment, and should not and ought not be the subject of legislation and for these reasons, the FMA opposes "Death with Dignity" legislation.

AMA-Physician Advertising—The Board was advised that the Federal Trade Commission has charged the AMA with prohibiting advertising of prices and services of its physicians as an illegal restraint on competition. The AMA plans to fight the antitrust suit.

FMA President, Dr. Astler, issued a news release on December 24, 1975 stating that the charges against the AMA were an attempt by the Federal Government to equate professional services rendered by physicians in providing medical care to individual patients to that of tradesmen bartering their goods in the market place.

U.S. Congress-Rural Health Week—The Board approved support and co-sponsorship with the AMA of a resolution currently before Congress establishing the week of April 4, 1976 as National Rural Health Week. (Approved R.C. II)

California Medical Society—Resolution re Use of Social Security Numbers—The Board reviewed a resolution to be submitted by the California Medical Society to the AMA regarding the use of Social Security numbers as identifiers. (Approved R.C. III)

RECOMMENDATION NO. 4

That the FMA support the resolution submitted by the California Medical Society regarding Social Security numbers:

WHEREAS in 1934, the Social Security Act was created as a social insurance vehicle; and

WHEREAS a number identifier was assigned to every covered insured; and

WHEREAS there are Federal regulations specifying the Social Security number may only be required for Social Security Administration and Internal Revenue Service purposes with all other uses being voluntary; and

WHEREAS the Department of Health, Education and Welfare is now considering the use of Social Security numbers as an identifier on all hospital records in order to enable the Bureau of Quality Assurance to tie medical records to an individual physician; and

WHEREAS the Social Security Administration mandates a twenty percent hospital sample submitted by the fiscal intermediary to the Social Security Administration on a taped record, and that confidential information is thus stored in a center government agency computer; and

WHEREAS PSRO's are mandated by law to remove all identifying characteristics of patients and physicians before submitting data to HEW and that the Social Security Administration has no such mandate under the law: Therefore be it

RESOLVED, That the FMA expresses its total opposition to the use of the Social Security number as a universal number identifier; and be it further

RESOLVED, That the FMA encourage all county societies, all PSRO's, all hosptials and other providers of medical care to oppose the use of the Social Security number as a universal number identifier. (Approved R.C. III) Motion adopted that a copy of this resolution concerning the use of Social Security numbers, including all supporting data be sent to each of the State Medical Associations and the AMA.

Department of Health & Rehabilitative Services—The FMA was unable to achieve the goal of establishment of a separate department of health in Florida during the 1975 session of the Legislature and the resulting reorganization of the massive Department of Health and Rehabilitative Services meant the abolishment of the Divlsion of Health thus leaving Florida as the only state in the U.S. without a centralized health delivery system.

The FMA has tried to encourage and ensure physician input in the implementation of the reorganization of HRS and to ensure adequate physician representation on HRS District Advisory Councils throughout the State. FMA has also sought to encourage the appointment of physicians to positions at the Assistant Secretary level particularly in positions directly responsible for health care delivery.

The radical districting that emerged from the 1975 Legislature was merely a social and welfare oriented program and health services was left as an abandoned stepchild. Many federal programs will not be funded, either by direct funds or matching funds, because there is no centralized health organization through which these funds may be channeled. It is also noteworthy that there has been no public health program originated since this diffuse reorganization and districting became law.

The morale of the personnel in the health care delivery system of this State is at its lowest ebb. Resignations, dismissals and early retirement is now the rule rather than the exception. A faint ray of hope has penetrated the horizon. A bill has been introduced by Rep. Earl Dixon which would remove health services from DHRS and establish a separate department of health. This bill has already received many co-sponsors and is almost identical to the bill introduced last year which has the endorsement of the FMA.

FMA Councils and Committees

The Delegates' Handbook will reflect the many hours of work that have gone into the activities of the Association's councils and their committees. Many physicians have given freely of their time in the program of the Association, and your Board is grateful for their dedication and interest in improving the quality and quantity of health care for the citizens of Florida. The following is a summary of the Board's actions regarding the recommendations of the councils. A complete summary report on the activities of all the Association's councils and committees is included in the Delegates' Handbook.

JUDICIAL COUNCIL

Grievance Procedures—The Board was advised that some county medical societies are not maintaining grievance procedures in a manner consistant with good patient, public relations and the Council is working with county medical societies to alleviate this problem.

Medical Malpractice Act of 1975—The Board had requested the Judicial Council to consider drawing up guidelines for implementation of the Medical Malpractice Reform Act of 1975, House Bill 1267, which requires professional medical associations, societies, and others to report disciplinary actions taken against members to the Florida State Board of Medical Examiners within 30 days of occurrence. Violators are subject to fines in an amount not to exceed $500. The Council reported that requirements appear to be quite simple and explicit to the point where guidelines are unnecessary. The Board acknowledged the need to inform Florida physicians of the requirements of the law.

This has subsequently been done through the FMA Briefs, FMA Journal and the Gray Paper. The State Board

of Medical Examiners has also sent out correspondence reminding physicians of their responsibilities under the law.

Amendment to the Medical Practice Act—Notice has been taken of proposed legislation which presumably will be considered by the 1976 Legislature to grant limited licenses to retired physicians from other states. It is understood that such licenses would entitle these physicians to render care to the elderly and poor only. Enactment of this or similar legislation could serve to lower the standard of medical care in Florida and would, in fact, pose a serious enforcement problem to the Florida State Board of Medical Examiners. (Approved R.C. III)

RECOMMENDATION NO. 5

That the Florida Medical Association actively oppose in the 1976 Legislature, bills to grant limited licenses to practice medicine in Florida to retired physicians from other states.

COUNCIL ON LEGISLATION AND REGULATIONS

Family Practice Residencies—The Board noted the need to increase funding for family practice residencies. Other residency programs have continuous funding support other than from state government and the major funding source of family practice residencies comes from state dollars. There is also a need for increased funding for other primary care specialties.

RECOMMENDATION NO. 6

That the Association actively support increased funding for Family Practice Residencies and Primary Care Physician Residencies; the Association also actively solicits increased funding for Community Hospital Education Programs. (Approved R.C. IV)

Regional Workshops—The Board approved FMA's participation in regional workshops to be set up for the purpose of educating Florida physicians on their political and governmental responsibilities, as well as actions being taken by the Association in the area of professional liability insurance. (Approved R.C. IV)

Contingency Fees—The Board adopted the position paper and goals for professional liability legislation as outlined in Dr. Astler's Statement to the Professional Liability Insurance Commission to include legislation to limit contingency fees. (Approved R.C. IV)

J.U.A.—The Board adopted the position paper and goals for professional liability legislation as outlined in Dr. Astler's Statement to the Professional Liability Insurance Commission with regard to the Joint Underwriting Association being made permanent. (Approved R.C. IV)

Mandatory Patient's Compensation Fund—The Board adopted the position of "Active Opposition" with regard to mandatory physician participation in the Patient's Compensation Fund. (Approved R.C. IV)

J.U.A. Regulating Commission—The Board approved a position of "No Position" with regard to the question of regulating commissions of insurance agents for policies sold in the Joint Underwriting Association. (Approved R.C. IV)

Acupuncture—The Board approved the recommendation that in view of the Association's position of "Oppose" to legislation which would create an acupuncture licensure law, spelling out detailed criteria concerning the use of such procedure by individual physicians, the Association endorse legislation which would establish standards for the operation of acupuncture clinics. (Approved R.C. IV)

School of Osteopathy—The Board approved the position of the Association with regard to a School of Osteopathy, as "Disapprove." (Approved R.C. IV)

Prescription Advertising—The Board approved that the position of the FMA with regard to legislation which would allow advertising of prescription drug prices be one of "No Position." (Approved R.C. IV)

Nuclear Medicine—The Board approved a position of "Endorse" for the efforts of the Florida Association of Nuclear Medicine Technologists to gain proper identification as technologists under Florida's Clinical Laboratory Act; and further, that such position be approved for similar types of technologists facing the same problem. (Approved R.C. IV)

Drug Substitution—The Board approved a position of "Oppose" to legislation that would allow substitution on prescriptions unless the physician in his own handwriting write "medically necessary." (Approved R.C. IV)

Reciprocity—The Board approved a position of "Oppose" to legislation which would modify the physician licensure laws in Florida with regard to opening up reciprocity. (Approved R.C. IV)

Office Signs—The Board approved a position of "Disapprove" of legislation requiring all physicians to display in their offices a sign stating "Consult your physician concerning the availability of the least expensive drug for your use." (Approved R.C. IV)

COUNCIL ON MEDICAL ECONOMICS

Disability Determination—The Board requested the Bureau of Disability Determinations, Division of Vocational Rehabilitation, to furnish the applicant for disability determination with a carbon copy of the letter requesting a medical report with the following sentence of the letter underlined: "The applicant is responsible for any costs involved in furnishing the information." (Approved R.C. V)

RVS-Guidelines for Co-Surgeons & Assistant Surgeons—The Board urged all county medical society insurance review committees to utilize the guidelines in the Florida Relative Value Studies as they pertain to payment for co-surgeons and assistant surgeons. (Approved R.C. V)

1975 RVS—[Referred to Board of Governors—R.C. V] The Board authorized publication of the 1975 Florida Relative Value Studies at the earliest possible date. The 1975 RVS follows the design and format of the 1971 RVS and, while differing in a number of respects, will appear familiar to regular manual users. It contains approximately 30 percent more procedures than the 1971 RVS.

The Committee held eleven meetings and one telephone conference, with four of the meetings lasting two days each. These meetings represent over 650 man-hours of meeting time which does not include each member's preparation time and travel. To prepare the survey questionnaires, mail to the membership, receive responses, compile and analyze results, required over 1,000 hours of work by FMA staff and approximately 1,200 hours by actuarial consultants.

The President expressed the appreciation of the Board for a job well done by the Committee.

Joint Meeting with Council on Specialty Medicine—The Board approved a joint meeting of the Committee on RVS and representatives of the Council on Specialty Medicine to review the procedures used for revising the RVS specifically as they relate to specialty group input. (Approved R.C. V)

Workmen's Compensation—The February 24, 1975 issue of "News Report" published by the American Federation of Physicians and Dentists stated.

"VICTORY IN FLORIDA . . .

> After the Florida Medical Association petition for an increase in compensation fees was denied by the Division of Labor, the United Physicians and Dentists of Florida prepared and submitted to the Bureau of Workmen's Compensation in Tallahassee, a fee schedule. This schedule was compiled for practitioners and specialists by using their own union members to work out usual, customary and fair fees for compensation cases. From direct efforts and

testimony at the Division of Labor Hearing in Tallahassee, the U.P.D.F. was able to obtain a 32 percent overall increase in compensation fees effective March 1, 1976."

It is a matter of record that the U.P.D.F. had no part in the efforts to have the fee schedule updated except to present a proposed fee schedule at the December 18, 1975 public hearing which was noted by the hearing officer not to be based on fees actually being charged.

The increase in the Workmen's Compensation Medical and Surgical Fee Schedule was a direct result of FMA's petition for an increase and the efforts of James F. Richards, M.D., both in testimony at the three public hearings and personal contact with the Department of Commerce. It was only after the FMA appealed the initial decision of the Department of Commerce to the First District Court of Appeals and a third public hearing was held that an increase in the fee schedule was granted.

RECOMMENDATION NO. 7

That the Florida Medical Association contact the American Medical Association and request that a rebuttal article be published in the "AMA News" regarding the claim of the United Physicians and Dentists of Florida that they were responsible for the recent increase in the Florida Workmen's Compensation Medical and Surgical fee schedule, and that the Florida Medical Association publish a rebuttal article in the "Briefs" and "Journal" regarding the claim of the United Physicians and Dentists of Florida that they were responsible for the recent increase in the Florida Workmen's Compensation medical and surgical fee schedule.

The Board of Governors wishes to commend Dr. James Richards for his diligent efforts on behalf of FMA in bringing about this increase in the Workmen's Compensation Fee Schedule. (Approved R.C. V)

COUNCIL ON MEDICAL SERVICES

Physicians Recruitment Conference—The Board approved FMA sponsorship of a physician recruitment conference to inform communities on the problems associated with setting up a practice in underserved areas and offer guidance as to how communities might attract physicians. The conference is scheduled to be held April 23 at the Flagler Inn in Gainesville. (Approved R.C. II)

State Task Force on Rural Health—

RECOMMENDATION NO. 8

That the FMA participate and provide the appropriate leadership in the formation of a statewide task force, consisting of members of the Florida Medical Association, state legislature and other concerned individuals, to evaluate the need for medical services in underserved areas, and to suggest possible solutions for providing health care delivery in underserved areas. (Revised R.C. II)

Primary Care Physicians—The Board commends the Board of Regents and the Community Hospital Education Council for their current and continued emphasis on primary care. (Approved R.C. II)

EMS Legislation—The Board approved legislation providing physician supervision and direction of all advanced life-support treatment such as carried out by emergency medical technicians—II personnel. (Approved R.C. II)

Additional State Funding for County Health Department—The Board expressed support for substantial increased state funding for county health departments. Due to inflation and a growing patient population, county health departments are having an increasingly difficult time providing services mandated by law. The state has not increased its share of funding for county health departments since 1969. (Approved R.C. II)

Minimum Standards for Health Agencies—The Home Health Services Act and Rules provide for the development, establishment, and enforcement of basic standards which will ensure the safe, adequate care of persons receiving health services in their homes under plans of treatment established by the person's physicians.

RECOMMENDATION NO. 9

That the FMA endorse the rules and regulations proposed by the Department of HRS concerning minimum standards for home health agencies. (Approved R.C. II).

Public Education—The Council on Medical Services believes that public education in emergency procedures is of vital importance. Emphasis needs to be placed in training of the general public and competent cardiopulmonary resuscitation and appropriate other medical emergency and self-help techniques.

RECOMMENDATION NO. 10

That the Florida Medical Association adopt the following position regarding CPR and basic life-support training:

I. That the Florida Medical Association support and encourage the broad based educational programs to train physicians and the general public in competent cardiopulmonary resuscitation and other appropriate medical emergency and self-help techniques, and

That implementation of such educational programs include:

A. Training programs in private and public educational systems to assure competence in CPR and basic life-support techniques of all students above the level of the eighth grade.

B. Availability and active promotion of CPR and basic life support training of all law enforcement officials, fire department personnel, athletic coaches and other public service personnel whose duties place them in a position of direct service to and exposure to the general public.

C. Active promotion of CPR and basic life-support training of the general public through business, professional, civic, social and other public organizations.

D. Active support of public relations and other educational and motivational programs to emphasize the need and requirements for the availability of such training programs.

E. Requirement for adequate supervision by and participation of the local medical society.

II. That the FMA strongly encourage each component society to establish training programs for its members and to encourage its members to show proficiency in CPR by either becoming certified, or in order to teach, becoming an Instructor-Trainer.

III. That cardiopulmonary resuscitation training conform to the standards propounded by the American Heart Association's CPR committee.

IV. That development of such programs be given a high priority. (Revised R.C. II)

Conference on EMS Public Education—The Board approved through the Florida Medical Foundation co-sponsorship of an EMS Public Education Conference for the purpose of determining ways of implementing the resolution on EMS Public Education. (Approved R.C. II)

Categorization of Critical Care Facilities—

RECOMMENDATION NO. 11

That the Florida Medical Association adopt the following resolution concerning categorization of critical care facilities:

WHEREAS the EMS Committee of the Florida Medical Association supports the concept of stratification of patients with certain clinical problems which have been shown to benefit from such stratification: Therefore be it
RESOLVED, That the Florida Medical Association endorse the basic concept of optimal care of catastrophic illness and injury for all Floridians as a proper and highly desirable goal of medicine and that the EMS Committee serve to determine hospital capabilities for providing optimal care to include, but not be limited to the following categories of medical problems:

1. Major trauma
2. Head and spinal cord injuries
3. Burns
4. Cardiac
5. Neonatal
6. Psychiatric
7. Drug and Alcohol
8. Emergency Departments

(Amended R.C. II)

Physician Supervision of Advanced Life-Support Techniques

RECOMMENDATION NO. 12

That the Florida Medical Association adopt the following resolution concerning advanced life-support techniques:

WHEREAS many locales have experienced difficulty in setting up advanced life-support programs and providing proper EMT II training; and
WHEREAS some established advanced life-support systems have demonstrated a lack of physician supervision; and
WHEREAS the Florida Medical Association recognizes that the application of advanced life-support techniques as a part of the practice of medicine: Therefore be it
RESOLVED, That no paramedical personnel may administer advanced life-support techniques except under the responsible supervision of a specific licensed physician or physicians; and be it further
RESOLVED, That any EMS system employing or utilizing paramedical personnel to perform advanced life-support procedures must employ or contract with or otherwise relate to a qualified physician or physicians to supervise the paramedical personnel functioning for that EMS system. (Revised R.C. III).

Commercial Medical Informational Service—Over the past year, several private companies have contacted the FMA in an attempt to obtain endorsement of their services. These services involve the accumulation of medical history and information that can be used in the event of an emergency. Subscribers are charged a fee and are provided either a microfilm of their history or some form of identification which a physician can use to obtain information from a central data bank.

RECOMMENDATION NO. 13

That the Florida Medical Association adopt as official policy the position statement regarding commercial medical information services (A copy of which is included in the delegates' packets). (Approved R. C. II).

COUNCIL ON MEDICAL SYSTEMS

Uniform Accounting & Cost Regulatory Commission—The Board approved a position of favoring a uniform accounting system and public financial disclosure for hospitals and nursing homes; in addition, that the FMA request the State of Florida to adopt a single reporting form to be used by all state agencies requiring reports from hospitals or physicians. (Approved R.C. V)

Foundations for Medical Care—The Board approved recognition of the Foundation for Medical Care of the Big Bend Area of Florida, Inc., and the West Florida Medical Foundation. Recognition includes representation on the Committee on Foundations for Medical Care. (Approved R.C. V)

Comprehensive Health Planning Committee—Urged that component county medical societies become actively involved in the appointment of members to Health Service Agencies and the Statewide Health Coordinating Council to make every effort to insure that there is physician input and guidance. (Approved as Changed R.C. V).

Response to Rules and Resolutions—

RECOMMENDATION NO. 14

That the Florida Medical Association adopt the following resolution regarding the time allowed for response to proposed rules and regulations and that it be forwarded to the Florida Congressional Delegation:

WHEREAS the proposed rules and regulations published by various state and federal agencies which are aimed at having widespread effects in the status quo of the

American business and professional scenes, and fail to coincide with the intent of legislation; and
WHEREAS these proposed rules and regulations, when published, are usually associated with no more than 30 days being allowed for pertinent response to these proposed rules and regulations; and
WHEREAS most business and professional organizations are constituted and function through representation by committee format; and
WHEREAS most of these organizations cannot possibly respond through their respective committees, councils, and boards of governors within the usually allowed 30 days in an ongoing regular fashion: Therefore be it
RESOLVED, That the Florida Medical Association approach our State and National Legislators to increase the time limit for pertinent response to proposed rules and regulations to 90 days. (Approved R.C. V)

Government Programs—The Board allocated time during the 1976 Annual Meeting for a meeting on government programs to brief the membership on items of pertinent medical interest, i.e., DHRS Reorganization, PSRO Legislation, PL 93-641, and HSA's. (Approved R.C. V)

Consortium—The Board authorized the Council to explore the possibility of establishing a consortium composed of the private sector to serve as the manager of health data so as to ensure the control of such data. (Approved R.C. V)

Medicaid-Contract to do PMUR—The Board of Governors approved the FMF proceeding with a contract to do peer review for the Medicaid program similar to that currently being done by the Committee on PMUR for Medicare. (Approved R.C. V)

COUNCIL ON SCIENTIFIC ACTIVITIES

CME Programs—The Board designated a committee of the Florida Medical Foundation for the purpose of conducting, sponsoring, or co-sponsoring AMA Category 1 CME activities. (Approved R.C. I)

Physicians Assistants—The Board authorized physicians' assistants to be admitted to FMA scientific programs in the company or at the request of their employer physicians, provided they are properly identified and they pay the registration fee for non-members. (Approved R.C. I)

Community Hospital Education Program—The Board received a report from the Committee on Medical Education regarding their meeting with representatives of CHEC and the concern expressed that not enough Florida medical graduates were engaged in CHEC residencies. The Committee on Medical Education was of the opinion that when the appropriate level of quality is reached in the CHEC training programs, the retention statistics will be improved, and that it would be worthwhile to investigate ways that the state might assist rural counties and communities in offering incentives to young primary care physicians to settle in those areas. (Approved R.C. I)

FIFTH PATHWAY

RECOMMENDATION NO. 15

Substitute Recommendation No. 15

That the Florida Medical Association reiterate its position that the so-called Fifth Pathway to licensure American graduates of foreign medical schools is not in the best interest of the people of Florida at this time.

That the FMA endorse the transfer of qualified and bona fide Florida residents to Florida medical schools at the third-level (Clerkship level), the implementation of such a program to be the distinct prerogative of each individual medical school. (Substitute Recommendation Approved R.C. I)

Continuing Medical Education—The Board adopted criteria for implementing the CME Program as enacted by the House of Delegates at its Interim Meeting in January, and has approved the procedures to be used by the Committee on CME in administering the program. (Approved R.C. I)

COUNCIL ON SPECIALTY MEDICINE

Specialty Group Recognition—The Board of Governors has approved recognition of the following specialty groups: (Approved R.C. I)

Florida Society of Pediatric Cardiologists
Florida Endocrine Society
Florida Association of Nuclear Physicians
Florida Society of Neonatal Perinatologists

This brings to 35 the total number of specialty groups recognized by the FMA which includes representation on the Council on Specialty Medicine.

NURSE PRACTITIONERS

RECOMMENDATION NO. 16

That the FMA recommend to the State Board of Medical Examiners that when and if a nurse practitioner or nurse assistant performs any act not covered by the Nurse Practice Act that these acts only be under the responsible supervision of a qualified physician and further that nurse practitioners not be allowed to bill for third party payments. (Approved R.C. I)

Florida Society of Ophthalmology—The Board approved implementation of the Florida Society of Ophthalmology's public relations campaign, "M.D. Means A Difference" to be coordinated with FMA's statewide public relations program.

The Board approved FMA's support of the Florida Society of Ophthalmology in every way possible to overturn the recent policy decision of the Florida State Board of Optometry allowing the use of drugs for diagnosis and treatment of disease by optometrists in Florida and further the Board notes that this policy decision was apparently advanced without due process and supports the protest to the Joint Administrative Procedures Commission that proper hearings and reviews were not carried out prior to development of this new policy. (Approved R.C. I)

PAYMENT OF PAP SMEARS

RECOMMENDATION NO. 17

[Referred back to the Board of Governors—R. C. I]

That the FMA encourage all government medical care programs and third parties, including Blue Shield, to consider pap smears as a necessary medical procedure and provide resimbursement to physicians for this procedure.

Florida Society of Colon and Rectal Surgeons—The Board approved the change in the name of the Florida Proctologic Society to, "The Florida Society of Colon and Rectal Surgeons." (Approved R.C. I)

COMMITTEE ON VOLUNTARY HEALTH AGENCIES

The Board approved official renewal of recognition for 1976-77 for 12 voluntary health agencies as outlined in the Committee's report to the House of Delegates.

The Board approved renewal of recognition tentatively for 1976-77 for the following voluntary health agencies which in the judgment of the Committee on Voluntary Health Agencies have apparently met the criteria established by the Association; and that the Chairman of the Committee be authorized to make a final determination as to these agencies pending review of additional material to be presented by them:

1. Florida Society for the Prevention of Blindness, Inc.
2. United Cerebral Palsy of Florida, Inc.
3. Muscular Dystrophy Association, Inc., Florida District

(Approved R.C. II)

Blue Shield

The Board received a report from Dr. Joseph Matthews, Chairman of the Blue Shield Board, advising that Blue Shield is presently confronted with several problem areas, including the increase of rates, performance problems, which will be alleviated by a new computer system, and pressures from the Insurance Department and the Federal Trades Commission concerning the composition of the Blue Shield Board. He stated that the main concern was the rising cost of medical care.

Committee on Nursing Homes

RECOMMENDATION NO. 18

That the Florida Medical Association adopt the following resolution regarding nursing home care:

WHEREAS nursing home care has received much attention in the press recently; and

WHEREAS the Legislature has expressed concern through proposed legislation relating to nursing homes; and

WHEREAS the Board of Governors of the FMA has acknowledged nursing homes and nursing home care as a possible problem and appointed a committee on nursing homes; and

WHEREAS the Committee has received Representative Sheldon's Ad Hoc Subcommittee on Nursing Homes report to the Committee on Health and Rehabilitative Services of the House of Representatives and it will take some time to consider, critique, and evaluate these recommendations; and

WHEREAS the Board of Governors recognizes a need for a positive position at this time: Therefore be it

RESOLVED, That the FMA formally express its concern about nursing homes and nursing home care and offer its continuing assistance and cooperation with legislative committees, HRS, Nursing Home Association, and other interested parties to study and help solve these problems; and be it

RESOLVED further, That the Nursing Home Committee continue to study the nursing home situation and report to the Board specific recommendations that may be suggested for administrative changes or included in next years' legislative program; and be it

RESOLVED further, That the FMA urge its membership to take a more active role in supervision of nursing home care in the State of Florida by participation on nursing home utilization review committees, fulfilling the role of the medical director when appropriate, and give continued follow-up care for patients in nursing homes. (Approved R.C. V)

Medicaid Task Force on Physicians' Services—The Board received a report from Dr. Donald Nikolaus, Chairman of the Subcommittee on Physicians' Services to the Task Force on Medicaid. The Board directed that Dr. Nikolaus' report, which outlines recommendations regarding Florida's Medicaid Program, be duplicated and included in the Delegates' Packets for information. (Approved R.C. V)

Committee on Cost of Medical Care

In a concentrated effort to assist in finding ways to stem the ever increasing costs of medical care, FMA President, Dr. Astler, has appointed a special committee to be composed of physicians and other knowledgeable individuals in the health care field. This committee will maintain close liaison with the appropriate legislative and governmental bodies. Areas that will be included in the committee's deliberations are health care data collection, the roll of the state and major private purchasers of health insurance in the area of cost containment, HMO's, supply and demand in hosptial costs, and reforms needed in the Medicaid program.

RECOMMENDATION NO. 19

After careful consideration, the Board of Governors submits the following recommendations to the House of Delegates for amendment to the FMA By-Laws.

AMENDMENTS TO THE BY-LAWS

OSTEOPATHY—FMA Membership

CHAPTER I.—MEMBERSHIP, Section 1—Qualifications and Eligibility - Insert an additional item to read:

"2. Any doctor of osteopathy who has satisfactorily completed an AMA approved internship and/or residency training program may be accepted into membership in the Florida Medical Association, Inc. upon certification by the secretary of his Florida Medical Association component society that he is a member in good standing of that society, provided such certification is accompanied by remittance of all required fees, dues, assessments and an archives data form."

Section 2—Classifications

Amend this paragraph to read:

"1. Regular Active Dues-paying Members.—Active Members shall be those Florida Licensed doctors of Medicine OR OSTEOPATHY who are certified to the Association by the several component society secretaries as unrestricted members in good standing and who fulfill the continuing medical education requirements . . ."

Amend the sixth paragraph to read:

"Associate Members shall be doctors of medicine OR OSTEOPATHY who may or may not be licensed to practice medicine in the State of Florida and who are certified by the secretary of a component society as members including:"

Amend Item 6 to read:

"6. Doctors of medicine OR OSTEOPATHY in career status with the United States Army, Navy, Air Force, Coast Guard, Public Health Service, Veterans Administration, and Indian Service, and other Federal appointees who do not hold membership in another state medical association."

Amend Item 7 to read:
"7. Doctors of medicine OR OSTEOPATHY of Florida State agencies who are ineligible for active membership."

Amend Item 8 to read:
"8. Doctors of medicine OR OSTEOPATHY serving obligatory military service as provided for in Chapter X, Section 2, Subsection 6."

Section 3—Rights and Privileges

Amend first paragraph to read:
"Membership in the Association confers no vested right to the holder thereof, but is a conditional privilege revocable for cause. Each doctor of medicine OR OSTEOPATHY and student, by accepting membership in the Association, becomes subject to all provisions of these By-laws, and subject to disciplinary proceedings authorized hereunder."

Section 4—Suspension or Involuntary Termination of Membership

Amend the first paragraph, last sentence to read:
". . . The commission by a member of any act contrary to honesty, justice or good morals, whether the act is committed in the course of his relations as a doctor of medicine OR OSTEOPATHY or otherwise, and whether or not the act is a crime, constitutes a cause for discipline."

CHAPTER XI.—COMPONENT SOCIETIES, Section 3—Membership

Amend Item 1 to read:
". . . Since membership in a component society is a prerequisite to membership in the Florida Medical Association and the American Medical Association, every reputable and licensed doctor of medicine, AND OSTEOPATHY, AS DEFINED IN CHAPTER I, SECTION 1, in his respective county who is practicing, or who will agree to practice, nonsectarian medicine shall be privileged to apply for membership."

Amend Item 2 to read:
"2. Appeals—Any doctor of medicine OR OSTEOPATHY who has been denied membership in the component society of his county, or who has been suspended or expelled, may appeal to the Judicial Council, which upon a majority vote, may grant him permission to apply for membership in an adjacent component society."

Amend Item 5 to read:
"5. Membership in Florida Medical Association Required.—Each component society holding a charter from the Association shall require all of its eligible members who are doctors of medicine OR OSTEOPATHY to be members also of the Florida Medical Association."

Section 4—Role of Component Society

Amend to read:
"Each component society shall assume general direction of the affairs of the medical profession in the area of its jurisdiction. It shall constantly strive for the scientific, moral and material advancement of all doctors of medicine AND OSTEOPATHY and for the improvement of medical services and health facilities locally."

House of Delegates—Privilege of Floor

CHAPTER IV—HOUSE OF DELEGATES, Section 14—Privilege of Floor

Amend the first paragraph to read:
"The privilege of the floor shall be restricted to seated delegates, officers, Presidents of the County Medical Societies, members of the Board of Governors, AMA delegates, past presidents, members of the Council on Specialty Medicine, Council Chairmen, and AMA GENERAL OFFICERS AND PAST PRESIDENTS who are FMA members, except by permission of the presiding officer."

Interns and Residents Dues

CHAPTER X.—INCOME AND EXPENDITURES, Section 2—Dues

Amend Item 1 to read:
"1. Annual Dues.—Annual dues shall be assessed, as hereinafter provided, by the House of Delegates and shall currently be . . . **$10.00** for medical interns and full time physicians in an approved residency or internship, . . ."

In item 6, delete the phrase:
". . . interruption of practice for postgraduate study for a period of time not to exceed four years . . ."

Executive Committee Composition

CHAPTER VII—BOARD OF GOVERNORS, Section 6—Executive Committee, Item 1—Composition

Amend this item by inserting the word TREASURER between "Secretary" and "Immediate Past President."

(Approved R. C. III)

President's Address

The Reference Committee advised that the time alloted for the President's Annual Address contained a most unusual and delightful bicentennial presentation by the "First Family" and that the result of this work was very rewarding to those who saw and heard it.

The motion of the Reference Committee that this very fine work by Diane and Vern Astler be filed carried.

Remarks of the Speaker

The motion of the Reference Committee that the remarks of the Speaker as presented be filed carried.

Report of AMA Delegates

The Reference Committee received the Report of the AMA Delegates with appreciation and pride in their accomplishments. It was noted that Dr. Jere Annis was re-elected for another term on the Board of Trustees of the American Medical Association and has been elected Vice-Chairman by the Board and Chairman of the Finance Committee.

It was also noted that the Chairman of the Delegation, Dr. Francis T. Holland is being supported for the position of Vice President of the AMA, a position which he richly deserves.

The motion of the Reference Committee that the Report of the AMA Delegates be filed, with expression of appreciation to the entire AMA Delegation, carried.

Report of the Florida Medical Foundation

The motion of the Reference Committee that the Report of the Florida Medical Foundation be filed with an expression of appreciation for a job well done, carried.

Report of the Florida Physicians Association, Inc.

The motion of the Reference Committee that the Report of the Florida Physicians Association, Inc., be filed with commendations for their continued excellent work, carried.

Judicial Council

The Reference Committee reported that it had been suggested that the members of the FMA be reminded of the mechanism for pursuing grievances against a doctor of medicine who is not a member of the Florida Medical Association. In such an instance, the county medical society may notify the Board of Medical Examiners directly, and the Executive Director of the Board can then deputize a member to investigate and report directly to the Board of Medical Examiners.

The motion of the Reference Committee to approve the Report of the Judicial Council, with thanks and gratitude for the continuing service which they perform in such an exemplary manner year after year, carried.

Judicial Council

William W. Thompson, Chairman

Various issues and questions associated with FMA's policy on physician listings in telephone directory yellow pages commanded a significant portion of the work of the Judicial Council during the Association year now ending.

These and many other matters were weighed by the Council during its meeting in Bal Harbour on April 27, 1975; in Tampa on September 13, 1975; and in Orlando on January 29, 1976.

The Council's activities are summarized under the appropriate headings below:

1. **Telephone Directory Yellow Page Listings**—In 1974, the House of Delegates enacted "Policy of the Florida Medical Association, Inc. Governing the Listing of Members in Telephone Directories (White and Yellow Pages)" (see Board of Governors Recommendation No. 6, Annual Meeting, 1974). The Judicial Council was, and is, of the opinion that various provisions of this policy delegate to it, the Council, authority to grant exceptions, interpret the rules, and make additions to the approved list of specialty headings. This it has been doing since the House approved the policy in 1974.

On April 27, 1975, the Council, reversing two previous decisions, did approve the heading "Surgery, Facial Plastic," for use in yellow pages. The Council made this decision in complete good faith after becoming convinced that facial plastic surgery had emerged as an important subspecialty in which both plastic surgeons and otolaryngologists receive considerable training in their residency programs.

Soon the Council found it had injected itself into a tempestuous controversy unparalleled in intensity in recent years. On one side were the otolaryngologists who supported the Council's decision; on the other side were the plastic surgeons who vigorously opposed it.

The summer of 1975 was a long, hot one for members of the Council who were inundated with scores of letters and telephone calls from the two sides, particularly the plastic surgeons, who carried the battle to the Board of Governors. On August 9, 1975, the Board, in its wisdom, stayed the Judicial Council's decision on "facial plastic surgery" and referred the matter to the Council on Specialty Medicine and back to the Judicial Council for reconsideration after consultation with the Florida Society of Otolaryngologists and the Florida Society of Plastic and Reconstructive Surgery.

At 2:00 p.m. on September 13, 1975, the Judicial Council conducted a hearing on this subject, which was attended by representatives of both specialty societies involved. Each side was given as much time as it needed to present its case. Afterward, with one member absent, the Council reaffirmed its approval of a heading for "Surgery, Facial Plastic."

Action by the House of Delegates, in interim session on February 1, had the effect of eliminating "Surgery, Facial Plastic" from the list of authorized headings inasmuch as the House decreed that headings would be restricted to specialties and subspecialties for which AMA-approved certification boards exist.

Other interpretations and declsions made by the Judicial Council regarding telephone directory listings include:

—Physicians who have incorporated under the Florida Professional Service Corporation Act may use "Chartered" in lieu of "P.A." after their names if that is the designation they chose under the provisions of the law.

—The Council denied the request of one otolaryngologist that the official heading for that specialty be changed.

—The Council was successful in having telephone companies accept separate headings for diagnostic and therapeutic radiology after they had combined all radiology listings under one heading.

—Under consideration but still not acted on is a request from the Florida Society of Dermatology that its telephone directory heading be changed to "Dermatology and Dermatologic Surgery."

—A county medical society which had under consideration a proposal to regulate directory listings locally was told this would be in direct conflict with the policy adopted by the House of Delegates.

—The Council believes that the term "geographical area" as it is used in Rule III—1 of the policy should be defined by individual county medical societies locally in the context of population centers, trade areas, routes of patient referral, transportation system, telephone systems, and other variables.

2. **Osteopathy**—The 1975 House of Delegates adopted Resolution 75-4, which resolved that the Florida Medical Association change its by-laws to allow county medical societies to accept as members osteopath physicians who are deemed to be qualified and who have also satisfactorily completed an AMA approved internship and/or residency training program. The Council was asked to suggest guidelines for admission of osteopaths to membership if and when this change is made in the by-laws. The Council is of the belief that inasmuch as osteopaths would be eligible only after completion of an AMA-approved graduate training program, no guidelines are necessary. However, the Council believes that those osteopaths who have completed acceptable programs should be judged on an equal basis with doctors of medicine for membership.

3. **Grievances**—Several appeals from decisions of county medical society grievance committees have been received and considered by the Judicial Council. In all cases, most of which arose from one particular county medical society, the patients rather than the physicians filed the appeals.

The Council has noted that two large county medical societies have a policy of communicating with complainants over the signatures of lay employees on the staffs. Members of the grievance committees remain anonymous. The Judicial Council has pointed out to these two societies that this is an undesirable practice and creates a barrier between the grievance committees and the complaining patients. Nevertheless, the two societies continue that practice.

It is apparent to the Council that some county medical societies follow grievance procedures that are less than satisfactory. For this reason, the Council developed and

approved, subject to review by legal counsel, "Procedures for Investigation and Resolution of Grievances Against Members of the Florida Medical Association, Inc." Inasmuch as they supplement the "Florida Medical Association Judicial Council Rules and Procedures" approved by the House of Delegates in 1972, they are quoted here:

PROCEDURES FOR INVESTIGATION AND RESOLUTION OF GRIEVANCES AGAINST MEMBERS OF THE FLORIDA MEDICAL ASSOCIATION, INC.

It is in the public interest and in the interest of organized medicine in Florida that the Florida Medical Association and its component medical societies adopt and maintain proper and effective procedures for adjudicating and resolving grievances filed by patients and other members of the public against member physicians.

The Florida Medical Association By-laws provide for the Judicial Council to ". . . direct and supervise the activities of the Association which pertain to questions of medical ethics, dissension and disputes referred to the Association for investigation and adjudication, complaints by patients against members of the Association and questions of membership and disciplinary action." (Chapter VIII (Councils), Section 3 (Duties, Functions and Composition), Subsection 1)

Rules and Procedures of the Judicial Council as adopted by the House of Delegates in 1972 assign to the Council "original jurisdiction, both as to fact and procedure" in grievance matters. In practice, however, the Judicial Council delegates original jurisdiction in patient complaints to the appropriate county medical societies, thereby establishing itself as an appellate body. However, if the county medical society refuses or fails to act upon a particular case within 180 days, the Judicial Council may, at its discretion, retrieve original jurisdiction and assign the case to the Committee on Membership and Discipline.

Responsibilities and Procedures of the Judicial Council

1. The Judicial Council will accept for investigation grievances filed against Doctors of Medicine and medical students who are members of the FMA. Complaints against non-member M.D.'s will be referred to the Florida State Board of Medical Examiners. Complaints against other health personnel will be referred to the appropriate professional organization or licensing board. Complaints against chiropractors, naturopaths and other cultists will be referred to the Florida State Board of Medical Examiners.
2. All complaints received by the Council must be in writing and signed. Complainants must identify all physicians involved and cite dates, places and events to the best of their ability. Complaints will not be processed until all basic pertinent information is supplied.
3. Once all names and details of a complaint are on hand, the FMA staff will make at least three additional copies of the file, which will be sent to:
 A. County Medical Society Grievance Committee
 B. Defendant physician(s)
 C. State Grievance Chairman
 D. Other parties, as indicated
4. The FMA staff will forward the case to the Grievance Chairman of the appropriate county medical society within seven working days of the date all principals are identified and pertinent details are provided by the complainant. Grievance Committee will be asked to act upon the complaint within 180 days from date of transmittal and to render a written report of findings directly to the complainant with a copy to the Judicial Council.
5. If the county society acts and renders a report within 180 days, the case will be considered closed unless either party to the dispute elects to appeal the decision of the county grievance committee to the appellate agency within the county society or to the Judicial Council.
6. If a complaint is not adjudicated expeditiously or satisfactorily, the State Grievance Chairman shall attempt to determine what has caused the delay or dissatisfaction and shall reopen the case on the Association level if such a procedure is deemed necessary and advisable. In the event a hearing for appeal at the state level is required, the State Grievance Chairman may request that a subcommittee of the Membership and Discipline Committee be appointed to conduct whatever additional investigation is indicated. Each such subcommittee shall communicate with all principals in the case assigned to it. Upon completion of its investigation, the subcommittee shall render a written report, including recommendations, to the State Grievance Chairman, who shall present the report along with his own recommendations at the next meeting of the Judicial Council.
7. At the discretion of the State Grievance Chairman, either party to a dispute may be granted permission to appear personally before the Judicial Council to present information pertinent to the case. In such cases, the opposing party will be offered the opportunity to appear. Except by unanimous vote, neither party will be accompanied by legal counsel.
8. In consideration of any case on appeal, the Judicial Council, by a majority vote of the members present, may take any of the following actions:
 A. Uphold and affirm all or parts of the report of the County Medical Society Grievance Committee, or the Membership and Discipline Subcommittee.
 B. Reject all or parts of the report of the County Medical Society Grievance Committee or Membership and Discipline Subcommittee and direct the appropriate entity to reinvestigate.
 C. Unilaterally suggest an alternate solution to the parties to the complaint.
9. Any member of the Judicial Council may be excused from sitting in judgment and participating in a particular case for sufficient cause. Any past, present, or contemplated future business, professional or social relationship with either party shall constitute sufficient cause.

Responsibilities and Procedures of the County Medical Society

It is assumed that each component medical society of the Florida Medical Association maintains at least one committee, whether it be known as the Grievance Committee, Mediation Committee, or whatever, whose principal purpose is to evaluate and to attempt to resolve complaints and grievances initiated by patients against member physicians. It is further assumed that each such committee functions under a procedure or protocol that protects the rights of the patients and the physicians and affords all parties the highest degree of fairness.

It should be kept in mind that for many people who have occasion to file complaints against physicians, the county medical society grievance committee is their only formal contact with organized medicine. With medicine under attack for allegedly not policing its own ranks, it is particularly important that each individual patient be accorded all respect, courtesy and fairness possible by the Grievance Committee and its individual members. Care should be taken that the Grievance Committee's actions do not give rise to charges of "whitewash," prejudice or inaction.

The following standards are suggested by the Judicial Council to assist county medical society grievance committees in meeting their commitments to organized medicine, individual physicians, the public, and complaining patients:

1. No county medical society member should accept appointment to a grievance committee unless he is totally committed to justice for physicians and patients alike. Neither should he accept appointment unless he is willing to make personal sacrifices from time to time in the interest of the justice to which

he is committed. He should not conceal himself behind a cloak of anonymity. On the contrary, he should allow himself to be visible and his name to be used in connection with the grievance committee. As a rule, all written communications with a complaining patient should be issued over the signature of the county grievance chairman or some officer of the Society. While it may be necessary from time to time for the executive director or some other employee of the Society to communicate with the patient, all decisions and most other correspondence should be signed by a physician.

2. A case may be referred to the grievance committee from any of several sources, including the Judicial Council, a state legislator or a congressman's office, the governor's office, or the Florida State Board of Medical Examiners, or the patient himself, or his attorney. Regardless of source, each complaint should be investigated and a report rendered as soon as possible. Failure of a county medical society to render a report within 180 days is cause for the Judicial Council to assume original jurisdiction.
3. Upon receiving a grievance, the Grievance Committee should begin its investigation immediately. Once all information is assembled, the Committee should meet and attempt to arrive at a decision. Whether the patient or the physician is invited to appear personally before the Committee is a matter for the Committee itself to decide. However, it is important that all parties to the complaint be offered equal rights and privileges.
4. The Grievance Committee should not undertake to investigate any case which is, concurrently, in litigation. If after the Grievance Committee has accepted a case litigation is undertaken, the Committee's investigation should be suspended immediately.
5. As soon as a decision is reached, the Committee should communicate its findings to the complainant with copies to go to all other interested parties, including the Judicial Council. In the event the case results in disciplinary action against a physician (reprimand, censure, suspension or expulsion, etc.), the county medical society must, under state law, report such action to the Florida State Board of Medical Examiners. This should also be reported to the Judicial Council.
6. Each county medical society should establish some type of intra-organizational appeal mechanism, whether it be through the board of trustees or directors, or some other entity within the Society. Both parties should be advised of his right to, and method of appeal.
7. Once all rights of appeal through the county medical society have been exhausted, the losing party should be advised of his right to appeal to the Judicial Council.

4. **Transfer of Records**—The Council has referred to the appropriate county medical society for investigation an interesting case involving transfer of medical records. One doctor left a partnership and established an office of his own. He apparently sent announcements and medical records release forms to many patients whose records were retained by the partnership.

5. **FTC/AMA Advertising Case**—The Federal Trade Commission's action against the American Medical Association last December in the matter of professional advertising is distressing to the Council. FMA President Vernon B. Astler, M.D., issued a statement on Christmas Eve in opposition to the FTC action, and the Judicial Council concurs and commends the President for that statement.

6. **Hospital Advertisement**—A West Coast hospital published an advertisement in a daily newspaper in that area with a suggestion that individuals without a physician contact one of its staff physicians. In the opinion of the Judicial Council, this advertisement is clearly unethical insofar as it pertains to physicians, and the county medical society was asked to counsel its members who are on the staff of the hospital.

7. **Abortion Clinics**—Many questions have been raised about certain activities of the many abortion clinics that have been established in Florida in recent years. One problem is the referral solicitations many of these clinics conduct among its own and nearby medical communities, a practice that is offensive to many physicians. Another objection frequently raised involves the itinerant surgeon who does abortions and returns to his home in a distant city perhaps without making adequate arrangements for handling post-abortion emergencies. The legal climate being what it is, the Judicial Council feels that it is virtually powerless to act on these questions.

8. **County Medical Society Factionalism**—The Judicial Council is watching closely an unfortunate situation in which one county medical society is almost evenly divided between two factions that are based on hospital loyalties. Alleging certain irregularities, one side has asked the Judicial Council to declare the most recent election of county society officers invalid and to order a new election. The Council has interviewed representatives of both camps and has admonished the county medical society to make every effort to settle its differences, resorting to binding arbitration, if necessary.

9. **Amendment to Medical Practice Act**—The Council has suggested to the Board of Governors that FMA actively oppose proposed legislation to grant limited licenses without examination to retired physicians from other states for the alleged purpose of providing additional medical care for Florida's elderly and poor.

10. **County Medical Society By-Laws**—Amendments and/or revisions to the by-laws of the Sarasota County Medical Society, the Martin County Medical Society and the Brevard County Medical Society were reviewed and approved.

11. **Liaison with Florida State Board of Medical Examiners**—The Council has continued its good working relationship with the Florida State Board of Medical Examiners. The Council tries to send a representative to every meeting of the Board. It is anticipated that the Council and its Membership and Discipline Committee will be working more often with the Board in the future as the Board moves toward full implementation of the Medical Practice Act amendments contained in the omnibus professional liability legislation of 1975.

12. **Surgical Assistant Fees**—In response to a question, the Council ruled that it is not unethical for one physician to use another physician as his assistant in surgery, which assistant would bill the patient for his services, if an assistant is required irrespective of whether house officers are available and provided it is of benefit to the patient.

13. **Interest on Court Judgments**—The Council held that in cases in which a court enters judgment against a patient in an account delinquency case and orders that interest be paid, the physician may ethically accept payment of the interest.

14. **Medical Malpractice Reform Act of 1975**—The Council has recommended to the Board of Governors that FMA advise county medical societies, specialty groups, medical staffs, and other organized medical groups of amendments made to Section 458.1201, Florida Statutes, relating to the reporting of disciplinary actions against physicians, as contained in the Medical Malpractice Reform Act of 1975. The Chairman of the Judicial Council and Dr. George Palmer, Executive Director of the Florida State Board of Medical Examiners, wrote articles on this subject, which were published in the October 1975 issue of **The Journal of the Florida Medical Association.**

15. **Release Form for Hospital Staff/County Medical Society Membership**—The Council reviewed a release form which some California hospitals require applicants for medical staff appointment to execute. By signing this form, the applicant authorizes the hospital or its representatives to obtain from other hospitals, insurance carriers, etc., without incurring liability, information useful in evaluating

his background. The Council believes that such a form, if put to use by Florida hospitals and perhaps county medical societies, would facilitate a flow of information that sometimes has been difficult to come by in the past. It was recommended to the Board of Governors that it promote the use of a similar form in Florida.

Resolution 76-4

FMA Headquarters Location

Dade County Medical Association

The Reference Committee advised this Resolution was not considered as no representative appeared before the Committee to sponsor it.

Resolution 76-5

Establishment of a Defense Fund Insurance Trust for Medical Liability Insurance Cases

Dade County Medical Association

The Reference Committee advised this Resolution was not considered as no representative appeared before the Committee to sponsor it.

Resolution 76-26

Woman's Auxiliaries to County Medical Societies

Brevard County Medical Society

The motion of the Reference Committee to adopt Resolution 76-26, carried.

Resolution 76-26

Woman's Auxiliaries to County Medical Societies

RESOLVED, That all county medical association or society members urge their wives to form and have chartered a Woman's Auxiliary to the county medical association or society, and that the executive committee of each county medical association or society encourage, guide and support the Woman's Auxiliary to their county medical society in all endeavors sponsored by them and approved by the county medical society and the Woman's Auxiliary to the Florida Medical Association.

The motion of the Reference Committee to approve the Report of Reference Committee No. III as amended carried.

The President requested Dr. W. Harold Parham, FMA Executive Vice President, to ask the members of the FMA Staff who were present to come to the podium and be introduced. Those staff members were Mr. Don Jones, Executive Director; Mr. Scotty Fraser, Director, Public Affairs; Mr. Bob Harvey, Director, Medical Services; Mr. John Richardson, General Business Manager and Comptroller; Mrs. Wanda McWaters, Assistant General Business Manager; Mr. Jan Fisher, Director, Public Relations; Mrs. Carolyn Kenyon, Assistant Director, Public Relations; Mr. Gordon Hubbard, (former Director, Insurance Department) Vice President and General Manager of PIMCO; Mr. Ed Hagan, Director, Scientific Department; Mr. Charles Murfin, Executive Director, FLAMPAC; Mr. John Thrasher, Legal Counsel for PIMCO and In-House Legal Counsel for FMA. Mr. Phil Gilbert, Director, Foundation Department; Mr. George Palmer, Manager, Capital Office; Mrs. Diane Nail, Director, Special Services Department; Mr. John French, Legal Counsel in Tallahassee, were not present.

The Speaker then announced the House of Delegates would meet in Executive Session and that the Executive Session would be limited to delegates only and those members with privilege of the Floor; an exception by ruling of the Chair included the Executive Vice President.

The Second meeting of the House of Delegates recessed at 5:00 p.m. to meet in Executive Session, and to reconvene Sunday morning at 9:00 a.m.

Third House of Delegates

The third meeting of the House of Delegates convened at 9:15 a.m. on Sunday, May 9, 1976, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with the Speaker of the House, Dr. Louis C. Murray, presiding.

Dr. John H. Parker, Chairman of the Credentials Committee reported 200 delegates were registered representing 28 counties, which constituted a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—O. Frank Agee, Henry J. Babers Jr., Thomas D. Bartley, George J. Caranasos, William B. Deal, J. D. Garlington, Gerold L. Schiebler, Joel Lipman (Student).
BAY—B. Phillip Cotton, James D. Phillips.
BREVARD—Lewis Bean, William Broussard, James E. Carter, Adrian R. Jensen, Laudie E. McHenry, Pat B. Unger.
BROWARD—Miles J. Bielek, Robert J. Brennan, Bruce B. Burgess, Andre S. Capi, Russell B. Carson, Milton P. Caster, Willis N. Dickens, Burns A. Dobbins, Richard S. Doyle, Joseph E. Gelety, James A. Jordan, David C. Lane, George P. Messenger, Roland K. Molinet, Ray E. Murphy Jr., Franklin B. Ott, James B. Perry, Thomas F. Regan, Anthony J. Vento, Juan S. Wester (Absent—F. Gary Gieseke, Theodore W. Hahn, Diran M. Seropian, William D. Wells).
CAPITAL—Robert A. Johnson, Nelson H. Kraeft, Robert N. Webster (Absent—Jack W. MacDonald).
CHARLOTTE—(Absent—Melvyn Katzen, Fred Swing).
CITRUS-HERNANDO—Randall Jenkins.
CLAY—Laurin Smith.
COLLIER—Edwin E. Dean, Nicholas Kalvin.
COLUMBIA—Barney E. McRae.
DADE—Edward Annis, William G. Aten, Luis Cabrera, Edmund Cava, Sol Center, Richard Clay, Jack Q. Cleveland, Vincent Corso, O. William Davenport, Joseph Davis, Richard Dever, John Devine, Charles Dunn, Isaac Egozi, Franklin Evans, A. Fernandez-Conde, Miguel Figueroa, Humberto Fontana, Ralph Frankel, Milton Goldman, L. Marshall Goldstein, Norman Gottlieb, Pedro J. Greer, Julian Groff, Leo Grossman, Walter C. Jones III, James Jude, Marshall Hall, Henry Hardin, Joseph Harris, Robert B. Katims, Harold Kaufman, Norman Kenyon, Banning G. Lary, Maurice H. Laszlo, Warren Lindau, Carlos Llanes, Rose London, Richard Miller, Miguel Mora, Wesley S. Nock, Thomas Noto Jr., Jorge Pena, Walter Sackett Jr., Robert Schiess, Janice Sherwood, Everett Shocket, Margaret Skinner, S. Peter Stokley, Chauncey Stone, Mario Stone, William Straight, Charles Tate, John Turner, Sheldon Zane (Absent—Joseph Amdur, Hilario Anido, Jose Bocles, Victor Dembrow, Richard Fleming, Stanley Mitchel, Moises Mitrani, Modesto Mora, Harold Norman, Oscar Sandoval, Dale R. Venning (student).
DESOTO-HARDEE-GLADES—Calvin Martin.
DUVAL—Samuel J. Alford Jr., Warren M. Barrett, William P. Booras, James L. Borland Jr., Doris N. Carson, Yank D. Coble Jr., Patricia C. Cowdery, Wilbert L. Dawkins Sr., Emmet F. Ferguson Jr., Charles P. Hayes Jr., John C. Kruse, Charles B. McIntosh, Faris S. Monsour Jr., Sanford A. Mullen, John A. Rush Jr., Guy T. Selander, William D. Walkett (Absent—Jack L. Sapolsky).
ESCAMBIA—Reed Bell, Theodore J. Marshall, C. Fenner McConnell, John H. Whitcomb (Absent—Eric F. Geiger, Henry M. Yonge).
FRANKLIN-GULF—(Absent—Joseph P. Hendrix).
HIGHLANDS—Donald Hartwell, (Absent—Glenn V. Hough).
HILLSBOROUGH—Frank C. Coleman, Richard G. Connar, Robert J. Courtney, I. M. Essrig, John C. Fletcher, J. Carlisle Hewitt, Richard S. Hodes, Donald Irvine, Victor H. Knight Jr., Thomas E. McKell, W. Mahon Myers, John Petrakis, Ralph M. Stephen, Harold L. Williamson.
INDIAN RIVER—Ferdinand F. Becker, John H. Terry.
LAKE—B. F. Brokaw, Thomas Weaver.
LEE—Larry Garrett, Stewart Hagen, Frances L. Howington, H. Quillian Jones Jr.
MADISON—(Absent—Frank Harrison).
MANATEE—Thomas R. Busard, Walter Graham, John D. Lehman, Roger A. Meyer.
MARION—C. Brooks Henderson, Samuel L. Renfroe.
MARTIN—(Absent—John F. Powers, Richard Q. Penick).
MONROE—Ronald Chase, (Absent—W. M. Whitley).
NASSAU—Theodore G. Panos.
OKALOOSA—W. W. Thompson, Eugene R. Valentine.
ORANGE—Clarence C. Bailey, Michael Ballard, Stephen A. Butler, Clarence M. Gilbert, Paul C. Harding, Allen K. Holcomb, Rufus M. Holloway, G. Brock Magruder, Joseph G. Matthews, Franklin B. McKechnie, James G. Richards Jr., James J. Schoeck, Thomas B. Thames, Robert E. Trumbo.
OSCEOLA—George A. Gant.
PALM BEACH—Carl Andrews, Vernon Astler, Curtis W. Cannon, J. Russell Forlaw, Luis Guerrero, Doris E. Lake, Charles Metzger, Richard B. Moore, Thomas Murphy, Roger Petersen, Reginald Stambaugh, Dick van Eldik (Absent—Jerry F. Cox).
PANHANDLE—Herbert E. Brooks, William F. Brunner.
PASCO—Stanley Chovnick.
PINELLAS—E. Eddy Burns, Charles K. Donegan, John W. Hamilton, David S. Hubbell, Roger A. Laughlin, Morris J. LeVine, James H. Miller, James M. Neill, Donald G. Nikolaus, David T. Overbey, Howard L. Reese, Walter, H. Winchester, Rowland E. Wood (Absent—Thomas M. Daniel, Richard D. Smith).
POLK—Sam J. Barranco, J. Gerard Converse, Frank J. Fischer, John Glotfelty, Wiley Koon, Willard E. Manry Jr., Paul A. Tanner Jr., Frank Zeller.
PUTNAM—Roy E. Campbell.
ST. JOHNS—W. W. O'Connell.
ST. LUCIE-OKEECHOBEE—Howard C. McDermid, William Meyer.
SANTA ROSA—(Absent—William Watson).
SARASOTA—John N. Carlson, Kenneth C. Kiehl, Douglas Murphy, Franklin Pfeiffenberger, Karl R. Rolls, Robert E. Windom.
SEMINOLE—John Johnson, Luis Perez.
SUWANNEE-HAMILTON-LAFAYETTE—Larry Radkins.
TAYLOR—John H. Parker Jr.
VOLUSIA—Octavius B. Bonner, James Carratt, Richard Dillard, Richard Snodgrass, William H. Harrison.
WALTON—(Absent—Howard F. Currie).
SPEAKER OF THE HOUSE—Louis C. Murray.
VICE SPEAKER—Charles J. Kahn.

Dr. Murray recognized the following distinguished guests: Dr. Clarence Dee, Florida Veterinary Medical Association; Heidi Van Slyke, R.D., President, Dietetic Association; Dorothy O. Feeney, President, Florida Chapter, American Association of Medical Assistants, Inc.; Dr. David Stone, Past President, Florida Podiatrists Association; Mrs. Ruth Jacobs, President, Florida Nurses Association; Mr. Gilbert Weise, President, Florida Pharmaceutical Association; Dr. Ed Annis, Past President, AMA. Dr. Murray asked Dr. Annis to present a few remarks to the House.

Dr. Annis commended the House of Delegates and the Florida Medical Association for their diligent and dedicated efforts. He stated that the business community is better acquainted with what the profession is trying to do and more important, why they are trying to do the things they are doing. Dr. Annis stated that medical matters must be kept in the hands of those in the medical profession and that there has been an ever increasing influence on the part of the spokesman for the medical profession. This is a result of what the Association has been able to accomplish in Tallahassee and in Washington. Dr. Annis stated that he had been before many Houses of Delegates across the country and that none have been more effective in their state and national leadership than Florida.



Edward R. Annis, M.D., Miami, Past President of the American Medical Association, can be spotted at virtually all FMA annual meetings. Here he addresses the House of Delegates.

Installation of the President

Dr. Astler stated that it has been his greatest professional honor to have been the President of the Florida Medical Association and acknowledged with appreciation and gratitude his office staff, the Palm Beach County Medical Delegation who nominated him, the House of Delegates who backed him professionally, the entire FMA staff both in Jacksonville and Tallahassee, his family and wife, and expressed a special note of thanks to Dr. W. Harold Parham, Executive Vice President who, he stated, had been his counselor, advisor, executive and his friend.

Dr. Astler presented the personal gavel and president's certificate to Dr. MaCris, the new President.

Dr. MaCris presented Dr. Astler with the Past President's pin.

Dr. MaCris accepted the gavel with pleasure and stated that he looked forward to serving the FMA as President this next year.

Dr. MaCris asked the members for a few moments to tell them about their Past President, Dr. Vernon B. Astler.

Dr. MaCris stated that Dr. Astler came into the office of President last year, saw what had to be done with regard to the professional liability program, and set about doing it. The two main problem areas were in state legislature and public opinion. The first area Dr. Astler handled by improving legislative action and the second area, by getting the situation to the public. Dr. MaCris applauded Dr. Astler for a job well done.



Outgoing President Vernon B. Astler, M.D., hands over the President's Gavel and Plaque to Jack A. MaCris, M.D., while House Speaker Louis C. Murray, M.D., who was chosen as President-Elect, looks on.



New President Jack A. MaCris, M.D. affixes the Past President's Pin to the lapel of his predecessor, Vernon B. Astler, M.D.

Dr. MaCris acknowledged Dr. W. Harold Parham and stated that his ability to encompass the entire scope of the activities of the FMA is truly amazing and whose zeal in protecting and preserving the principles involved in the private practice of medicine are unsurpassed by anyone in this room. Dr. MaCris said that he would do his utmost on behalf of anything that promotes the patient's welfare and oppose anything which does not. He asked for the support of the members during his year as President.

The President requested Dr. Forlaw and Dr. Metzger to accompany Mrs. Astler to the podium where he presented Dr. Astler's portrait to her.

The Speaker resumed the Chair and asked Dr. G. Brock Magruder and Dr. Joseph Matthews to escort Mrs. Robert E. Zellner to the podium to receive the posthumous award of the Certificate of Merit to Dr. Robert E. Zellner.

CERTIFICATE OF MERIT

(Awarded Posthumously)

WHEREAS, The late Robert E. Zellner, M.D., of Orlando, was a distinguished and respected member of the Florida Medical Association for almost three decades; made outstanding contributions to the Association, the profession of medicine, the public, his community and country; and merits special recognition for his achievements; and

WHEREAS, This accomplished physician, born in Lakeland, Florida, on March 2, 1915, attended Lakeland High School; received the Bachelor of Science degree in 1936 from the University of Florida, and Doctor of Medicine degree in 1940 from Rush Medical College, University of Chicago; completed an internship at Grady Hospital and undertook further specialized training at Orange Memorial Hospital in Orlando; and

WHEREAS, This dedicated physician entered the U.S. Naval Reserve Medical Corps and was assigned to the U.S. Marines where he attained the rank of lieutenant and faithfully served from 1942-1946; and

WHEREAS, This honorable physician began private practice of medicine in Orlando, specializing in general surgery, following discharge from the United States Naval Reserve in 1946; and



The Certificate of Merit, FMA's highest honor, was awarded posthumously to Robert E. Zellner, M.D., of Orlando, who died on February 23, 1975. Here, Mrs. Zellner accepts the award from House Speaker Louis C. Murray, M.D.



Mrs. Vernon B. Astler is escorted to the podium to join her husband by Charles E. Metzger, M.D., Boca Raton, and J. Russell Forlaw, M.D., Boynton Beach.

WHEREAS, This servant of medicine gave himself untiringly in dedicated service to the Association, performing ably as President of the Florida Medical Association (1962); President of the Orange County Medical Society; a member of the Board of Governors and of many committees of the Florida Medical Association; President of the Florida Association of General Surgeons; Delegate to the American Medical Association; and President and later Board Chairman of Blue Shield of Florida, Inc.; and

WHEREAS, This prominent native son of Florida used his influence for the betterment of his home community through participation in civic affairs; was past director of the Orlando Rotary Club, and held numerous offices in the First United Methodist Church of Orlando: as Trustee, member of the Administrative Board; and

WHEREAS, When Robert Zellner spoke, his colleagues listened attentively for his tongue always imparted wisdom and enlightenment; and

WHEREAS, The untimely death of Robert Zellner on February 23, 1975, deprived Florida of one of its outstanding leaders and took from Florida medicine one of its most distinguished and esteemed members; therefore be it

RESOLVED, That the Certificate of Merit, the Florida Medical Association's highest honor, be awarded posthumously to our esteemed colleague, eminent Association member and dedicated community and professional leader in recognition of the unselfish and generous expenditure of time and effort throughout his life on behalf of the public, the profession and the Association.

Dr. Murray asked Dr. Harold Williamson and Dr. Ralph Stephan to escort Dr. Thomas E. McKell to the podium to receive the Certificate of Appreciation.

Certificate of Appreciation

WHEREAS, Thomas E. McKell, M.D. of Tampa, a respected member of the Florida Medical Association, through his service as Chairman of the Committee on Foundations for Medical Care and PRO; as a member of the Council on Medical Systems and of the Committee on Medical Education and in many other capacities, has made an invaluable contribution to the health and well-being of the people of our state and nation, and therefore merits special recognition for his achievements; and

WHEREAS, This distinguished physician was born at Starkville, Mississippi, in 1915; attended local schools; received his premedical education at the University of Mississippi and the degree of Doctor of Medicine from the University of Tennessee in 1939; completed an internship at T.C.I. Hospital, Birmingham, and a residency at Mississippi State Sanitorium in 1941; and



Thomas E. McKell, M.D., Tampa, receives FMA's Certificate of Appreciation from House Speaker Louis C. Murray, M.D.

WHEREAS, As a young physician he served his country in the U.S. Army Medical Corps from 1941 to 1945 attaining the rank of Major; and

WHEREAS, This faithful servant of medicine completed a Fellowship in Internal Medicine and Gastroenterology at Ochsner Clinic from 1946 to 1948; and

WHEREAS, He became an Instructor of Medicine at Tulane University in 1948 and taught there until 1951; and

WHEREAS, In 1951, this noted physician entered private practice in Tampa and joined the active staff of Tampa General Hosptial where he has served as Chief of Staff, Director of Professional Services, Director of Emergency Services; and

WHEREAS, Dr. McKell contributed his time, his knowledge and his experience to benefit the people in his community by serving as Chairman of the Tampa Area Hospital Council; Chairman of the Medical Advisory Committee, University of South Florida College of Medicine; Board of Directors, Florida Medical Foundation; Clinical Professor of Medicine, University of South Florida College of Medicine; member of Task Force Gulf Coast Health Planning Council; member of Board of Directors, Blue Shield of Florida; Medical Services Coordinator, Department of Health and Rehabilitative Services, State of Florida; President, Florida Gastroenterology Society; Hillsborough County Health Planning Council; member of the District Six Advisory Council; Department of HRS; member of Hillsborough County Medical Association; Florida Medical Association; American Gastroenterological Association; American College of Physicians, American and Florida Societies of Internal Medicine, Southern Medical Association, American Medical Association; has published numerous scientific articles and books related to his field; therefore be it

RESOLVED, That the Certificate of Appreciation, established for the purpose of acknowledging exceptionally meritorious service, be presented to this devoted member of the Florida Medical Association in recognition of his many contributions to the people of this state and nation, and to the profession of medicine.

The Speaker requested Dr. Robert Katims and Dr. Charles Tate to escort Dr. Wesley S. Nock to the podium to receive the Certificate of Appreciation.

Certificate of Appreciation

WHEREAS, The health and welfare of children in Florida and elsewhere have been enhanced and advanced by the presence and involvement of Florida's adopted son, Wesley S. Nock, M.D.; and

WHEREAS, Dr. Nock was born at Chicago, Illinois, in 1910; attended local schools; received his pre-medical education at the University of Idaho and the degree of Doctor of Medicine from Loyola Medical School in Chicago in 1938; completed an internship at West Suburban Hospital, Oak Park, Illinois, and residencies in Chicago in 1942; and

WHEREAS, This fine physician served his country in the United States Naval Medical Corps from 1943 to 1946 attaining the rank of Lieutenant Commander; and

WHEREAS, He entered private practice in Chicago where he practiced medicine for a year-and-a-half before moving to Florida to set up practice; and

WHEREAS, This faithful servant of medicine, served as chairman of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association; delegate to the White House Conference on Children and Youth, chairman of the FMA Committee on Child Health, the School Health Medical Advisory Committee to the Department of Education and Division of Health, Department of Health and Rehabilitative Services of Florida, served on task force committee on Health Education Teacher Programs and headed a Florida team attending the national conference on Drug Abuse Education sponsored by the U. S. Office of Education, and served as Chairman of the Dade County Medical Association's School Health Committee; and

WHEREAS, This eminent physician has had a prominent role in school health education and has contributed much personal time to promoting an educationally and medically sound health program in Florida schools; therefore be it

RESOLVED: That the Certificate of Appreciation, established for the purpose of acknowledging exceptionally meritorious service, be presented to this devoted member of the Florida Medical Association in recognition of his many contributions to the people, most especially to the children of this state and nation, and to the profession of medicine.

Dr. Murray asked Dr. MaCris to introduce his family.

Dr. Murray announced the continuation of the Reference Committee reports.



New FMA President Jack A. MaCris, M.D., of St. Petersburg, and Mrs. MaCris.

Report of Reference Committee No. IV

Legislation and Miscellaneous

Dr. Robert J. Brennan, Chairman of Reference Committee IV, presented the report of the Reference Committee.

Council on Legislation and Regulations

It was noted by the Reference Committee that the assessment adopted at the January meeting is being effectively utilized in the Legislative Program. The utilization of a part of this assessment to engage the assistance of highly qualified special staff in both the legislative effort and public relations effort had proven most successful in the opinion of the Committee. Accordingly, the Reference Committee encouraged the judicious use of these assessment funds to further the Association's goals in whatever forum is appropriate and necessary.

The motion of the Reference Committee to approve the Report of the Council on Legislation and Regulations as printed in the Handbook carried.

Council on Legislation and Regulations

James B. Perry, Chairman

Most of the work of the Council on Legislation and Regulations is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation—This committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this committee have kept in close touch with their assigned Senators and Congressmen on national legislative matters of interest to the FMA and American Medical Association.

As reported to the House last year, the emphasis of the Committee during the past year has been to encourage individual key contact physicians to conduct visits to Washington to allow them on a one-to-one basis, to discuss the key medical issues with their Congressman. Prior to the visit, each key contact physician was briefed by the AMA Washington office so that he would enter into the discussions with his Congressman thoroughly briefed as to the latest legislative status of key medical legislation. This format of congressional contact has proven to be very effective and will continue to be a major program of the committee during the coming year.

The annual AMA/AMPAC Public Affairs Workshop has been rescheduled for 1976. The Committee on National Legislation will be well represented at the workshop, and there will be many other key Florida physicians in attendance.

During the past year, the President of the Florida Medical Association, Vernon B. Astler, M.D., was invited to testify before the House Ways and Means Committee. It had been reported by members of the Florida national delegation that Dr. Astler did an outstanding job in presenting the views of Florida physicians with regard to the critical issue of national health insurance. The committee wishes to commend Dr. Astler for his leadership role in this very important effort.

The major legislative project of the Committee during the coming year will continue to be one of monitoring the national health insurance situation and developing a mechanism for implementation of any congressional contact action that might be needed.

Committee on State Legislation—The Committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Eight formal meetings of the committee have been held, along with informal conferences among committee members as items of an urgent nature arose.

The committee is particularly pleased with the results of the Interim Meeting of the House of Delegates as a mechanism for finalizing Association priorities in the area of professional liability legislation.

Consistent with the policies developed by the FMA House of Delegates the committee has worked closely with the Board of Governors in developing our legislative program for the 1976 session of the Florida Legislature.

The recent assessment has enabled the Association to add additional staff and consultant personnel to the Capital



John C. Kruse, M.D., Jacksonville, Chairman of the Committee on State Legislation (at microphone), provides Reference Committee IV (Legislation and Miscellaneous) with information. Others left to right: Ms. Diane Dickerson, Recorder; Robert J. Brennan, M.D., Ft. Lauderdale, Chairman; John A. Rush, Jr., M.D., Jacksonville; and Vincent P. Corso, M.D., Miami.

office which has greatly increased the capacity to follow the seemingly endless legislative proposals affecting physicians in Florida. With the expanded support made possible by the assessment, the Capital office is able to focus an aggressive and competent legislative effort toward achieving passage of the priority legislative objectives in the area of professional liability.

During the past year, several county medical society executives came to Tallahassee during the period while the Legislature was in session, and this proved to be most helpful to the Capital office in getting legislative support from the larger metropolitan areas. The committee intends to encourage this same procedure during the coming year.

The following items summarize the Committee's activities:

1. The Capital office is continuing to function under the supervision of Donald S. Fraser, Jr., Director of the Public Affairs Department of the FMA. He has been materially assisted by George Palmer, Jr., Manager of the Capital office, who has greatly increased the capacities of the Association to maintain close coordination with the county medical societies on legislative activities. During the past year, a legislative analyst, Mrs. Nancy Moreau, has been added which gives the Capital office the capacity to do independent analysis and research on the more important legislative matters being considered. Continuing emphasis is being placed on using the resources of the Capital office to provide better services and coordination for the medical specialty groups.

2. The Capitol Dispensary—The Committee has continued to place major emphasis on the working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day program. At the present time, efforts are being made to locate a physician to be in charge of the Capitol Dispensary on a day-to-day basis working with Mrs. Hart.

3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. A program has been undertaken to work with each county medical society in reviewing their assigned key contact physicians to make sure that the best possible physician is assigned this critical task.

4. Publications—A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A special publication has been instituted to communicate with members of the FMA on the current status of the professional liability legislative effort. This special publication will be mailed on a regular basis in addition to the legislative bulletin.

5. 1975 Legislative Accomplishments—During the 1975 legislative session, there were more than 300 legislative proposals that required action by the state legislative committee or the Capital office staff. Matters of major interest to the Florida Medical Association were:

—Passage of an omnibus bill on professional liability by the 1975 session of the Legislature. It included a majority of the priority objectives that the FMA had set in this area for the 1975 session. The specific provisions advocated by the FMA were:
 a. Informed Consent
 b. Statute of Frauds
 c. Statute of Limitations
 d. Ad Damnum Clause
 e. Establishment of Mediation Panels

—Defeat of legislation which would have established a rate commission for hospitals and nursing homes.

—Defeat of legislation which would have established a School of Osteopathy.

—Defeat of legislation which would have established licensure for acupuncture in the State of Florida including licensure of individual physicians before they could practice acupuncture.

—Defeat of legislation to give limited staff privileges to hospitals for chiropractors. This bill was amended so that chiropractors had access only to reports of laboratory tests and x-rays.

—Defeat of legislation establishing mandatory continuing education for physicians in order to be licensed in Florida.

—Defeat of legislation to restructure the Blue Shield Board so that at least 50% of it would be composed of consumers.

—Defeat of legislation which would place a layman on the State Board of Medical Examiners.

—Defeat of legislation which would have required physicians to submit to patients itemized bills understandable in layman's terms in treatment rendered. This defeated legislation would have included a 14-day waiting period before any payment could be made by third party carriers, so the patient would have time to examine bills rendered and contest the validity of the same.

—Amendment of the Nurse Practice Act so that nurse practitioners could engage in only those activities which are spelled out in rules and regulations agreed to by a separate subcommittee composed of the State Board of Medical Examiners and the State Board of Nursing.

6. Major Legislative Objectives for the 1976 Session—The major legislative objectives for the 1976 Session of the Florida Legislature as established by the FMA House of Delegates, and FMA Board of Governors were:

—Maximum utilization of Association resources to bring about relief in the professional liability insurance crisis. Priorities established include:
 *a. Definition of Malpractice
 b. Limitation of General Damages
 c. Requirement that plaintiffs would be liable for defense costs, including attorney's fees for cases appealed beyond the mediation panel.
 d. Structured settlement, offset for collateral sources
 e. Doctrine of Res Ipsa Loquitur
 f. Revision of the mediation panel law to provide for the establishment of expert panels to be used in determining the amounts of damages awarded in the malpractice judgments.

—The opposition to legislation which would establish a rate commission for hospitals and nursing homes rates and other general legislation which attempts to create specific utility type regulations for health care.

—Opposition to repeal of Florida's anti-drug substitution laws.

—Opposition to legislation which grants hospital staff privileges to chiropractors.

—Opposition to legislation which would establish reciprocity for medical licensure beyond the current authority of the State Board of Medical Examiners, including such mechanisms as the "Fifth Pathway" and licensure of retired physicians without their taking the state examination.

—Opposition to legislation which would weaken the ability of the State Board of Medical Examiners to carry out its functions, including placing a layman on the Board and taking away the right of the Board to hire its own legal counsel and investigators.

—Opposition to legislation which would require physicians to submit to patients an itemized statement understandable in layman's terms of services rendered, and which would also require a waiting period of 14 days in which the patient would be able to contest bills rendered prior to payment by third parties.

*See Board of Governors Report for report on expanded emphasis in these areas.

On the positive side, the Council on Legislation and Regulations has been actively working with other Councils and Committees to develop concepts aimed at bringing immediate relief to availability of medical care in specific geographical problem areas and problems of maldistribution of certain medical specialties. In addition, the Council has begun working with the new FMA-sponsored Committee on Cost of Medical Care in anticipation that it can be demonstrated to the Legislature that the private sector can more effectively carry out programs aimed at medical and hospital costs than can a government controlled system.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA Legislative program made during the 1976 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

Supplemental Report

Council on Legislation and Regulations

The motion of the Reference Committee to approve the Supplemental Report of the Council on Legislation and Regulations as printed carried.

Supplemental Report

Council on Legislation and Regulations

James B. Perry, Chairman

This is to update the report of the Council on Legislation and Regulations printed in the Delegates' Handbook. This report reflects the status of legislation as of April 30, 1976.

LEGISLATIVE STATUS OF FMA'S 1976 LEGISLATIVE PROGRAM

1. **Professional Liability Legislative Program.**

As of the date of this report, the House of Representatives is still conducting hearings on the FMA's professional liability legislative package. On April 27, the Senate Commerce Committee adopted a committee substitute for SB 525 which contains the following items from the FMA's professional liability legislative package:

a. Recovery of defense costs
b. Implementation of pretrial mediation panels
c. Limitations on general damages in the amount of $250,000
d. Structured pay out of future damages
e. Definition of medical professional negligence
f. Application of collateral sources in settlements
g. Definition of medical expert witnesses
h. Prohibition against the use of res ipsa loquitur doctrine in professional negligence actlon

The Commerce Committee package also contains an advance payment concept based upon a hospital self-insurance trust created by mandatory participation on the part of all physicians on the hospital staff. Under this concept the physician will be treated as an agent of the hospital and would only carry private professional liability insurance for occurrences that happen outside the hospital. Determination of advance payment to be made to the patient would be made by a risk management committee created from the hospital staff. At the present time, the FMA staff is working to separate this concept which has many undesirable features, from the basic tort reforms as originally proposed by the Association.

Additional items of the Association's professional liability legislative package which have been filed but not yet heard are:

a. Absolute two year statute of limitations (SB 1086)
b. Limitations of attorney's contingency fees (SB 383, HB 2395)

2. **Opposition to Legislation to Establish a Rate Commission for Hospital and Nursing Home Rates (HB 1705, SB 798, HB 3951).**

Legislation establishing a rate review mechanism, HB 1705 is still in House Committee on Finance and Taxation and the House Committee on Appropriations. HB 3951, which establishes the mechanism to carry out rate review but delayed the effective date for one year, is referred to the House Committees on Regulated Industries and Appropriations. SB 898, which in its original form attempted to accomplish the same purpose, has been amended in the Senate HRS Committee to place the responsibility in the Department of Insurance. It has also been amended to delete the section which allows the commission to become a rate review mechanism effective July 1, 1977.

3. **Opposition to the Repeal of Florida's Anti-Drug Substitution Law.**

The House Commerce Committee adopted legislation which would repeal Florida's anti-drug substitution laws (CSHB 2950). This bill now goes to the House Calendar and is currently being heard by the Senate Commerce Committee (SB 796).

4. **Opposition to Legislation Which Grants Hospital Staff Privileges to Chiropractors (SB 620, HB 3223).**

The Senate bill has been referred to Senate HRS Committee and has not yet been brought up for hearings. The House bill, HB 3223, was voted unfavorably by the House Subcommittee on HRS.

5. **Opposition to Legislation Which Would Establish Reciprocity for Medical Licensure, Including Such Mechanisms as the Fifth Pathway and Licensure of Retired Physicians Without the Necessity of Taking the State Examinations.**

a. Fifth Pathway—Legislation has been filed (SB 491, HB 2546) which would require medical schools to allocate 10% of their classes to Fifth Pathway students. These bills are still in committee.

b. License to retired physicians without examinations—Bills have been filed in both the House and Senate (HB 2456, HB 2534, SB 601) but have not yet been scheduled for committee hearings. Legislation did pass the House of Representatives (HB 1899) which would allow the State Board of Medical Examiners to grant temporary licenses to physicians without the necessity of taking the regular licensing examination, provided they practice in a clinic which is established in an area of need, certified by the Board of Medical Examiners and limit their practice to persons below the poverty income level.

6. **Opposition to Placing Layman on the State Board of Medical Examiners and Restrictions on the Board's Ability to Hire Legal Counsel and Investigators.**

a. HB 1555—Restricts the right of the Board to retain legal counsel and investigators. This bill is still in the Committee on Regulated Industries.

b. A layman on the State Board of Medical Examiners (SB 715, HB 3906). SB 715 passed out of the Governmental Operations Committee but was amended to eliminate two consumers from the State Board of Medical Examiners from the original bill. The House bill is referred to Regulated Industries Committee.

7. **Opposition to Legislation Which Would Require Physicians to Submit Patients an Itemized Bill Understandable in Layman's Terms.**

The original bill (HB 2528) was defeated by the Insurance Subcommittee, and there are two additional bills filed on this subject, HB 3375 which is referred to Commerce Committee and SB 1143 which is referred to Commerce Committee.

8. Status of Other Items of Concern to the Association.

a. Legislation to require the majority of the Blue Cross and Blue Shield Boards to be composed of consumers from health service agencies (SB 593). This bill passed out of the House Committee on HRS and is now on the Senate Calendar.

b. Legislation to provide hospital staff privileges to podiatrists and osteopaths (HB 3796). This bill has been referred to HRS Committee.

c. Assessment of $100 per physician and dentist to provide subsidies to physicians going into practice in areas of need (SB 716). This bill is referred to Senate HRS Committee.

d. Legislation to make continuing medical education mandatory as a condition to practice medicine in Florida (SB 1025). This legislation has been referred to the HRS Committee.

9. Concentration of Health Statutory and Regulatory Powers in the Department of Health and Rehabilitative Services Office of the Deputy Assistant Secretary for Health Planning.

The Council on Medical Systems has joined the Council on Legislation and Regulations in urging the Florida Medical Association to give high priority to the implementation of PL 93-641 in Florida by the Department of Health and Rehabilitative Services and particular attention to the activities of the Office of the Deputy Assistant Secretary for Health Planning. After receiving proposed health legislation, the Council has concluded that attempts are being made on the part of some state legislators and the Office of the Deputy Assistant Secretary for Health Planning to concentrate authority over planning and regulating health delivery and health care in the office of the latter. This effort is very apparent in the desire of the Office of the Deputy Assistant Secretary for Health Planning to legislate the private sector out of data collection, health planning, rate review and regulation. Also, the Council calls the Board's attention to the efforts on the part of these same people to propose legislation calling for advisory or policy boards for various state health programs and insisting that these boards must include consumers representing the public interest, yet they go on to stipulate that these consumer members are to be selected from the State Health Coordinating Council or the governing body of an HSA and not from the public at large. In addition, staff responsibilities for these programs are assigned to the DHRS Office of the Deputy Assistant Secretary for Health Planning. Examples of this are SB 898 and HB 3957 and the "linkage bill." The latter was developed by the staff of the Office of the Deputy Assistant Secretary for Health Planning and supported by the State Comprehensive Health Planning Council. This drafted legislation would call for the DHRS to establish a health data support center and require all providers by law to submit whatever data the DHRS feels it needs to do "health planning." In conclusion, the Council strongly feels that Florida does not need a "Czar of Medicine" nor does it feel that the Department of Health and Rehabilitative services should be the single state agency responsible for planning, evaluating, and regulating health. These responsibilities must be divided in order to assure proper checks and balances. We urge certain legislators and the Department of Health and Rehabilitative Services to experiment with their programs, take a leadership role in developing effective cost containment measures, insure quality of medical care in their institutions, and develop a computerized concurrent review system based on quality of care to measure their effectiveness.

OTHER LATE DEVELOPING LEGISLATIVE ACTIVITIES

The Council would ask for permission to introduce at the Reference Committee any items of major significance that might have arisen in the Legislature between April 30 and the time of the FMA meeting.

Board of Governors Report

Health Planning Resources Development Act of 1974

The motion of the Reference Committee that the Board's report on the Health Planning Resources Development Act of 1974 be adopted as printed in the Handbook carried. (See Report of Board of Governors, Page 511.)

Professional Liability

The motion of the Reference Committee that the Board's report on Professional Liability be approved as printed in the Handbook carried. (See Report of Board of Governors, Page 511.)

Contingency Fees

The motion of the Reference Committee that the Board's report on Contingency Fees be approved as printed in the Handbook carried. (See Report of Board of Governors, Page 512.)

Mediation Panels

The motion of the Reference Committee that the Board's report on Mediation Panels be approved as printed in the Handbook carried. (See Report of Board of Governors, Page 512.)

Recommendation No. 3

Death With Dignity Legislation

The Reference Committee moved that the Board's report on Death With Dignity Legislation be adopted. A motion from the floor to refer Recommendation No. 3, Death Wth Dignity, back to the Board of Governors for further study carried. (See Report of Board of Governors, Page 512.)

Council on Legislation and Regulations

Family Practice Residencies

The motion of the Reference Committee that the Board's report on Family Practice Residencies be approved as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

Regional Workshops

The motion of the Reference Committee that the Board's report on Regional Workshops be approved

as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

Contingency Fees

The motion of the Reference Committee to approve the Board's report on Contingency Fees as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

JUA

The motion of the Reference Committee to approve the Board's report on JUA as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

Mandatory Patient's Compensation Fund

The motion of the Reference Committee to approve the Board's report on Mandatory Patient's Compensation Fund as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

JUA Regulating Commission

The motion of the Reference Committee to approve the Board's report on JUA Regulating Commission as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

Acupuncture

The motion of the Reference Committee to approve the Board's report on Acupuncture as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

School of Osteopathy

The motion of the Reference Committee to approve the Board's report on the School of Osteopathy as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

Prescription Advertising

The motion of the Reference Committee to approve the Board's report on Prescription Advertising as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

Nuclear Medicine

The motion of the Reference Committee to approve the Board's report on Nuclear Medicine as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

Drug Substitution

The motion of the Reference Committee to approve the Board's report on Drug Substitution as printed in the Handbook was carried. (See Report of Board of Governors, Page 514.)

Reciprocity

The motion of the Reference Committee to approve the Board's report on Reciprocity as printed in the Handbook carried. (See Report of Board of Governors, Page 515.)

Office Signs

The motion of the Reference Committee to approve the Board's report on Office Signs as printed in the Handbook carried. (See Report of Board of Governors, Page 514.)

Resolution 76-3

Binding Arbitration

Dade County Medical Association

The Reference Committee advised that insomuch as no sponsor appeared in support of this Resolution, it was not considered.

Resolution 76-6

Childrens Medical Services Funding

Pinellas County Medical Society

The Reference Committee submitted a Substitute Resolution for Resolution 76-6.

Substitute Resolution 76-6

Medical Services Funding

RESOLVED, That the FMA seek adequate funding for the various state rehabilitative services programs (e.g. Childrens Medical Services, Vocational Rehabilitation, etc) and be it further

RESOLVED, That if adequate funding cannot be obtained, these programs be held in abeyance until adequate funding is available.

The motion of the Reference Committee to adopt Substitute Resolution 76-6 carried.

Resolution 76-11

Hospital Insurance Level—M.D.

Everett Shocket, M.D., Delegate

[Not adopted—Referred to the Board of Governors]

The Reference Committee moved that Resolution 76-11, Hospital Insurance Level—M.D., be disapproved. There was discussion, and a motion from the floor to refer the Resolution to the Board of Governors carried.

WHEREAS, the cost of so-called malpractice protection (insurance or trust) will increase, and

WHEREAS, This is such a significant cost of practicing medicine that must be distributed fairly and equitably among our patients, and

WHEREAS, The overwhelming majority of malpractice action relates to hospital care, and

WHEREAS, Hospital cost-accounting lends itself to rapid pattern analysis, and

WHEREAS, Some third party insurers (including government programs like Medicare and Medicaid) relate directly to recognizable costs, therefore, be it

RESOLVED, That the Florida Medical Association through persuasion and legislation seek a pattern wherein hospital professional liability policies will be written to protect the physicians in that institution from action arising from care given in that institution and that the cost be identified and the hospital appropriately compensated.

Resolution 76-14

National Health Insurance

Panhandle Medical Society

The Reference Committee advised it had heard considerable testimony as to the definition of "Catastrophic" and offered a substitute Resolution.

Substitute Resolution

National Health Insurance

The motion of the Reference Committee to adopt Substitute Resolution 76-14 carried.

Substitute Resolution 76-14

National Health Insurance

RESOLVED, That the Florida Medical Association adopt a position in favor of catastrophic health insurance funded by the private insurance sector of the insurance industry, and be it further

RESOLVED, That the Florida delegation to the AMA be instructed to introduce and support this concept as the official position of the American Medical Association.

Resolution 76-17

Drug Package Inserts

Polk County Medical Association

The motion of the Reference Committee to adopt Resolution 76-17 as printed in the Handbook carried.

Resolution 76-17

Drug Package Inserts

RESOLVED, That the Florida Medical Association strongly opposes passage of Kennedy Bill S-2697, which would fine a doctor $10,000 for each day of prescribing a drug for an indication not listed on its package insert; be it further

RESOLVED, That the drug package insert should not be made a legal document for punishment of physicians by Federal agencies or civil courts, but should remain an unofficial guide for medical practitioners in their own evalaution of risk vs. benefit in individual cases; and further be it

RESOLVED, That any proposed legislation which in any way would rigidly restrain use of good judgment by a licensed physician in carrying out duties to individual patients, or would propose search of a patient's hospital or office records by governmental agencies, should be condemned by patients, physicians, courts, and the Congress, and be it further

RESOLVED, That this resolution be submitted to the Florida members of Congress and to members of appropriate Congressional Committees.

Resolution 76-21

Nurse Practice Act of 1975

Hillsborough County Medical Association

The Reference Committee offered a substitute for Resolution 76-21 and moved its adoption. A motion to amend was made from the floor in the form of a substitute for the Reference Committee's substitute resolution. The motion to amend carried.

Substitute Resolution 76-21

Nurse Practice Act of 1975

RESOLVED, that the Florida Medical Association work with the State Board of Nursing **and the State Board of Medical Examiners** and participate in the scheduled public hearings on the proposed rules and regulations to implement the Nurse Practice Act of 1975, and be it further

RESOLVED, that the Florida Medical Association oppose any extension of Nursing practice when such extension might be detrimental to good patient care, **and be it further**

RESOLVED, that if the above efforts do not succeed in defining the limits of Advanced Nursing practice acceptable to the recognized Joint Committee of the State Board of Nursing and the State Board of Medical Examiners, then the Florida Medical Association should proceed to seek remedial legislation to that end.

The Reference Committee observed that the interim meeting of the House held in January 1976 was extremely helpful in providing advance guidance and policy direction to the Association's legislative program. The Board was urged to consider the possibility of holding a yearly interim meeting.

The motion of the Reference Committee to approve the substitute Resolution presented by the Duval County Medical Society was adopted.

The motion of the Reference Committee to adopt the report of Reference Committee No. IV as amended carried.

Report of Reference Committee No. V
Medical Economics

The Speaker, Dr. Murray, called for the report of Reference Committee No. V, Medical Economics.

Dr. R. B. Moore, Chairman, and members of the Reference Committee came forward to present the report of Reference Committee No. V.

Council on Medical Economics

The Reference Committee commended Dr. Richards and his Council for their diligent work on behalf of the Association.

The motion of the Reference Committee to adopt the report of the Council on Medical Economics was adopted.

Council on Medical Economics

James F. Richards Jr., Chairman

The Council on Medical Economics has had a very active year. Due to the size of the Council (three members) it became evident that it was more economical and efficient to conduct some of the Council business by telephone conference meetings. Three telephone conferences were held during the year on September 29, 1975, January 14, 1976, and March 3, 1976. The Council considered recommendations of its committees: The Committee on Relative Value Studies, Chairman, Charles K. Donegan, M.D., St. Petersburg; and the Committee on Health Insurance, Chairman, George L. Ford, M.D., West Palm Beach.

The Council was very active on other occasions through representation of the Chairman and members of the Council at various meetings with representatives of state government and private industry.

Cost Containment—The Chairman was involved in lobbying and testifying on behalf of the Association regarding legislation introduced in 1975 in the area of cost containment. Specifically, the Cost Containment Act of 1975, which would have created a Commission in Tallahassee, the function of which would have been to review and set rates for all private hospitals and nursing homes in the state, was defeated. The Chairman appeared before the Senate HRS Committee in February 1975 and again in March 1975 and before the House Committee later in the spring. It is anticipated that similar legislative efforts will be annually recurrent.

Workmen's Compensation Medical and Surgical Fee Schedule—Through the efforts of the Council a 32 percent across-the-board increase in the Workmen's Compensation Medical and Surgical Fee Schedule was obtained. On April 9, 1975 the FMA filed a petition with the State of Florida requesting an update in the Workmen's Compensation Medical and Surgical Fee Schedule. Following this, a meeting was held with the Workmen's Compensation Advisory Council on May 19, 1975 in Tallahassee. An additional meeting with representatives of the Bureau of Workmen's Compensation was held June 16, 1975 in Jacksonville. Three public hearings, July 31, 1975, August 25, 1975 and December 18, 1975, were held in Tallahassee to review the Workmen's Compensation Medical and Surgical Fee Schedule. At these hearings we presented testimony that proved that the Fee Schedule should be updated to reflect Usual and Customary Fees under the Workmen's Compensation Program. The Workmen's Compensation Law states "All fees and other charges for such treatment or service shall be limited to such charges as prevail in the same community for similar treatment of injured persons . . ." We argued that the prevailing fee represented the 90th Percentile or Usual and Customary as recognized by industry, both the insurance industry and many large corporations purchasing insurance for their employees. We also recommended the most current coding and nomenclature be reflected in an updated fee schedule rather than the archaic four-digit system currently in use by Workmen's Compensation. We asked that Workmen's Compensation



Richard B. Moore, M.D., West Palm Beach (center) presided over Reference Committee V (Medical Economics). Left to right: John H. Whitcomb, M.D., Pensacola; Walter C. Jones III, M.D., Coral Gables; Dr. Moore; Ms. Jan Taylor, Recorder; and Karl R. Rolls, M.D., Sarasota.

adopt the Florida Relative Value Studies with certain specific conversion factors.

After the August 25th hearing, our petition was denied completely. The FMA appealed the decision to the First District Court of Appeals as outlined in the Administrative Procedures Act. Upon this action, we were contacted by the Division of Labor, and we agreed by joint stipulation to recall the appeal in order to allow an additional public hearing which was held on December 18. On Christmas Eve, 1975, we were granted the 32 percent across-the-board increase which goes into effect March 1, 1976. Although the specific requests of FMA were not granted, this represents the greatest single increase ever granted under the Workmen's Compensation Program.

Several inadequacies still remain in the new Medical and Surgical Fee Schedule. One of these is that the new Fee Schedule does not recognize the various levels of office and hospital visits, such as limited, intermediate and comprehensive. Another deficiency is that the 32 percent increase did not adequately correct the fees for surgery and anesthesia, and these remain below the prevailing fees within the state. This Council also believes that the Fee Schedule should be updated annually. It will continue to keep under advisement and consideration the correction of the above mentioned deficiencies. James F. Richards, Jr., M.D. has been appointed by the Department of Commerce to the Workmen's Compensation Advisory Council, and it is hoped that through this appointment and the presence of three additional physicians on that Council that the FMA will be kept abreast of developments in the Workmen's Compensation Program and also have direct input to the Advisory Council.

Department of HRS Fee Schedule—The Council has continued ongoing negotiations with the Department of Health and Rehabilitative Services regarding its maximum reimbursement schedule for all departmental programs. On December 17, 1975 a meeting was held in Tallahassee with representatives of the Department of HRS concerning the Department's Fee Schedule. The Council has furnished the Department with data to show the inadequacies of the present Fee Schedule while simultaneously presenting information from the 1975 RVS in an attempt to have the Department adopt the 1975 RVS and update the Fee Schedule at the same time. A Task Force has been set up within the Department to study the Fee Schedule, and it is hoped that an update in this Fee Schedule will result in the near future.

Committee on Relative Value Studies—The Committee on Relative Value Studies met five times in Tampa, Florida and held one telephone conference. Meetings were held on June 28-29, 1975, July 12-13, 1975, August 16-17, 1975, October 1, 1975 and November 16, 1975. A telephone conference was held on August 26, 1975. The Committee surveys of the membership were completed, and the past year was devoted to analyzing and compiling the data to be included in the 1975 Florida RVS. Our consultants, William M. Howard, Ph.D., and Elinor Bowman, M.S., provided sound technical advice on all phases of the RVS preparation and conducted the survey and statistical operation smoothly and promptly.

Work on the 1975 RVS was essentially completed at the November 16, 1975 meeting although numerous telephone calls between committee members, staff and consultants have been necessary to clarify and coordinate several minor details.

Blue Shield of Florida has been working with the Committee during the revision of the RVS and has informed us that the coding and terminology of the 1975 Florida RVS will be incorporated into their Manual for Physicians. If we can convince the Department of HRS to utilize the 1975 Florida RVS as the basis for its Department fee schedule, we will be ever closer to the principle of a uniform coding and terminology system, if not nationwide, at least within the state of Florida.

The 1975 RVS is presently at the printer and should be available for distribution in March.

Committee on Health Insurance — The Committee on Health Insurance held one meeting during the year on August 23, 1975. Through the Committee and staff, liaison with Blue Shield of Florida was maintained. The Committee confronted no major problems during the year because of direct communication between the FMA and Blue Shield at the Board level. The involvement of the Committee in Blue Shield activities was kept to a minimum.

The Committee has continued to maintain communications with the Health Insurance Association of America which represents about 90 percent of the health insurance industry.

We would like to thank all of those members of FMA who gave their time at the request of the Council and came to Tallahassee to testify on behalf of FMA and the petition to revise the Workmen's Compensation Medical and Surgical Fee Schedule and would also like to thank those FMA members who gave of their time and contributed to the revision of the Florida RVS. Both of the committees within this Council deserve a great deal of thanks and credit for the many long hours and conscientious deliberations on behalf of FMA.

Council on Medical Systems

The motion of the Reference Committee to approve the report of the Council on Medical Systems was adopted.

Council on Medical Systems

James L. Borland Jr., Chairman

The Council on Medical Systems continued its efforts to establish a state professional review organization. After reviewing numerous manual and computerized medical review systems, the Council advised the Board of Governors that the Florida Medical Association should consider the possibility of developing its own concurrent computerized review system. Concurrent systems such as the one developed by the Medical Advances Institute (MAI) are still one to two years away from being perfected and economically feasible.

Last year the Council reported that an agreement for peer review for the Florida Medicaid Program was imminent. However, due to the reorganization of the Department of Health and Rehabilitative Services, discussions were suspended and only recently reactivated. The Council is optimistic that an agreement will soon be reached in which our Committee on PMUR will conduct medical peer review for Medicaid modeled after what is currently being done for Medicare.

Federal and State Government continue to try to control medical data. The Council, in an effort to keep the management of data in the "private sector" has recommended to the Board of Governors that the Florida Medical Association explore with the Florida Hospital Association, Florida Blue Cross and Blue Shield, and other interested parties the establishment of a consortium which, in turn, can become the state medical data support center.

The Council acted as the "Steering Committee" for an FRMP-FMF project designed to provide funds to county medical foundations for educational seminars in medical peer review and support systems. Four such seminars were held around the state.

A brief summary of each committee's activities for the year is presented in this consolidated Council report. Several recommendations of the Council were previously submitted to, and acted upon by, the Board of Governors and appear in its report.

The Committee on PMUR continued to provide retrospective medical peer review for the Florida Medicare program under an agreement between the Florida Medical Foundation, Blue Shield of Florida, GHI, and the Bureau of Health Insurance, Social Security Administration. Also,

this Committee performed health insurance review for the Association.

The Committee on Hospitals and Extended Care Facilities conducted a **two-day seminar entitled "The Role of the Medical Director in the Skilled Nursing Facility"** which drew three-hundred-eighteen participants, ninety-eight of whom were medical doctors. The AMA reported this seminar to be the largest of this nature held anywhere in the country to date.

The Committee on Government Programs kept the Association appraised of state and federal activities which had impact on the medical profession. The workload of this Committee has become so great that the Council has recommended that it be divided into two subcommittees, one on federal programs and one on state programs.

The Committee on Foundations for Medical Care and PRO has examined extensively numerous computerized review systems in an attempt to find one concurrent system based on quality of care assessment that could be used as a base for a Peer Review Organization. Unfortunately, the federal government is currently interested in retrospective review and thus the developers of systems have concentrated in this area. Only the concurrent system developed by Medical Advances Institute (MAI) was found to be designed for use by physicians. MAI is still a year or two away from being perfected and available at an acceptable cost.

Report of Board of Governors

Resolution 75-10

Release of Medical Records to Insurance Carriers

The motion of the Reference Committee that the Report of the Board of Governors be approved and that Resolution 75-10 be filed carried. (See Board of Governors Report, Page 511.)

Resolution 75-9, 75-12, 75-19 and 75-21

Medicaid Certification and Review Regulations

The Chairman advised that the Reference Committee had reviewed the Board of Governors report relating to these four resolutions and noted that the AMA has been successful in court in obtaining a preliminary injunction which essentially fulfills the thrust of the above resolutions.

The motion of the Reference Committee that the Board report relating to Resolutions 75-9, 75-12, 75-19 and 75-21 be approved and that the foregoing resolutions be filed carried. (See Board of Governors Report, Page 511.)

FMIT Program-Psychiatric Benefits

The motion of the Reference Committee that the Board action on FMIT Program-Psychiatric Benefits be approved carried. (See Board of Governors Report, Page 511.)

Seminar on Medical Directors in Skilled Nursing Homes

The motion of the Reference Committee that the Board's report on Seminar on Medical Directors in Skilled Nursing Homes be approved carried. (See Board of Governors Report, Page 511.)

Utilization Review

The motion of the Reference Committee that the Board's report on Utilization Review be approved carried. (See Board of Governors Report, Page 512.)

National Health Insurance

The motion of the Reference Committee that the Board's report on National Health Insurance be approved carried. (See Board of Governors Report, Page 512.)

Medicaid—Physicians Services

The motion of the Reference Committee that the Board's report on Medicaid—Physicians Services be approved carried. (See Board of Governors Report, Page 512.)

Disability Determination

The motion of the Reference Committee that the Board's report on Disability Determination be approved carried. (See Board of Governors Report, Page 514.)

RVS-Guidelines for Co-Surgeons and Assistant Surgeons

The motion of the Reference Committee that the Board's report on RVS-Guidelines for Co-Surgeons and Assistant Surgeons be approved carried. (See Report of Board of Governors, Page 514.)

1975 RVS

The Reference Committee recommended approval of the Board's report on the 1975 RVS, however, there was a motion from the floor for disapproval of the report with particular emphasis on Section 48, page 43 of the RVS Publication, "Reduced Anesthesia Value for Supervision" After discussion, a motion to refer the report on the 1975 RVS back to the Board of Governors for reconsideration of Section 48, page 43, "Reduced Anesthesia Value of Supervision" for possible deletion or to be re-

written carried. (See Report of Board of Governors, Page 514.)

Joint Meeting with Council on Specialty Medicine

The motion of the Reference Committee that the Board's report on the Joint Meeting with Council on Specialty Medicine be approved carried. (See Report of Board of Governors, Page 514.)

Recommendation No. 7

Workmen's Compensation

Reference Committee V reviewed the report of the Board of Governors regarding the activities of the Council on Medical Economics in its negotiations with the Florida Department of Commerce, Bureau of Workmen's Compensation, regarding a new fee schedule for Workmen's Compensation cases, including Board Recommendation No. 7.

The motion of the Reference Committee that Recommendation No. 7 of the Board of Governors be adopted and promulgated with dispatch carried. (See Report of Board of Governors, Page 514.)

Uniform Accounting and Cost Regulatory Commission

The motion of the Reference Committee that the Board's report on Uniform Accounting and Cost Regulatory Commission be approved carried. (See Report of Board of Governors, Page 516.)

Foundation for Medical Care

The motion of the Reference Committee that the Board's report on Foundation for Medical Care be approved carried. (See Report of Board of Governors, Page 516.)

Comprehensive Health Planning Committee

The Reference Committee reviewed the Board's Report relating Comprehensive Health Planning Committee and had been informed that such activities are now performed by organizations designated as Health Service Agencies. The Committee changed the wording ". . . local and state health planning committees and councils," to "Health Service Agencies and the Statewide Health Coordinating Council."

The motion of the Reference Committee to approve the Board's report on Comprehensive Health Planning Committee as changed carried. (See Report of Board of Governors, Page 516.)

Recommendation No. 14

Response to Rules and Regulations

The motion of the Reference Committee to approve the Board's report and Recommendation on Response to Rules and Regulations including the Resolution embodied therein carried. (See Report of Board of Governors, Page 516.)

Government Programs

The motion of the Reference Committee to approve the Board's report on Government Programs carried. (See Report of Board of Governors, Page 517.)

Consortium

The motion of the Reference Committee to approve the Board's report on Consortium carried. (See Report of Board of Governors, Page 517.)

Medicaid Contract to do Peer Review

The motion of the Reference Committee to approve the Board's report on Medicaid Contract to do Peer Review carried. (See Report of Board of Governors, Page 517.)

Blue Shield

The motion of the Reference Committee to approve the Board's report on Blue Shield carried. (See Report of Board of Governors, Page 518.)

Committee on Nursing Homes

The motion of the Reference Committee to approve the Board's report on Committee on Nursing Homes and Recommendation No. 18 including the resolution embodied therein carried. (See Report of Board of Governors, Page 518.)

Medicaid Task Force on Physicians' Services

The motion of the Reference Committee to approve the Board's report on Medicaid Task Force on Physicians' Services carried. (See Report of Board of Governors, Page 518.)

Resolution 76-1

Equal Coverage for Mental Illness

Dade County Medical Association

The Reference Committee advised that it had considered this resolution and heard testimony to the effect that in the past, mental illness has, in multiple insurance plans, been inadequately covered. The Reference Committee agreed that health insurance should include equal coverage for all illnesses. The Committee was appraised of prior House of Delegates policy against mandating insurance coverage for any particular diagnosis, illness, or mode of treatment. The Reference Committee considered Resolution 76-1 at significant variance from this adopted policy.

The Reference Committee moved that Resolution 76-1 be disapproved. The motion carried.

Resolution 76-8

Criteria for Medical Audit

Lee County Medical Society

The Reference Committee reported that it had considered Resolution 76-8 and heard testimony maintaining that cost and length of stay had become an overbearing and all-consuming impetus in medical audit. The Reference Committee also heard testimony that cost of care and length of hospital stay are indeed related to the quality of medical care. Therefore, feeling that these two factors bear some relation to the quality of medical care, though not a prime relationship, the Reference Committee changed Resolution 76-8 by changing the words "not to be included in" to "be maintained in proper perspective".

The motion of the Reference Committee to adopt Resolution 76-8 carried.

Resolution 76-8

Criteria for Medical Audit

RESOLVED, That the Florida Medical Association write to the Joint Commission for Accreditation of Hospitals and request that cost and length of hospital stay be maintained in proper perspective in criteria for medical audit; further be it

RESOLVED, That the Florida Medical Association delegates introduce to the American Medical Association House of Delegates a similar resolution at the next meeting of the American Medical Association House of Delegates.

Resolution 76-9

Blue Shield of Florida

Hillsborough County Medical Association

The motion of the Reference Committee to adopt Resolution 76-9 carried.

Resolution 76-9

Blue Shield of Florida

RESOLVED, That the House of Delegates of the Florida Medical Association continue its support and express its confidence in the Board of Directors and the staff of Blue Shield of Florida.

Resolution 76-10

JCAH and Audit Position

Everett Shocket, M.D., Delegate

The Reference Committee had heard testimony relating to the relationship of the AMA and JCAH, which indicated that these two organizations, through their actions, maintain inconsistent policy toward proposed 24-hour admission review rules. In considering the resolution as presented, the Committee found it difficult to interpret the terms "not to be tolerated" and "Resolved immediately". The Committee accepted the premise that the inconsistent posture of the two organizations does not appear logical by the two related health organizations and submitted a substitute resolution for Resolution 76-10.

The motion of the Reference Committee to approved the Substitute Resolution carried.

Substitute Resolution 76-10

JCAH and Audit Posture

RESOLVED, That the House of Delegates of the FMA go on record as favoring some solution of the problem of inconsistent stance between the JCAH and the AMA as regards the 24-hour admission review rules.

Resolution 76-12, Hospital Requirement of M.D. Insurance, Everett Shocket, M.D., Delegate and Resolution 76-22, Mandatory Malpractice Insurance Coverage, Volusia County Medical Society.

The Reference Committee considered these two resolutions together inasmuch as they are very similar in intent. The Reference Committee had heard testimony pro and con regarding the legality of requirements for professional liability insurance coverage as a requirement for hospital staff membership. The Committee believed that case law charging hospital governing boards with basic responsibility for hospital staff qualifications has up to this point

been sustained. The Committee, therefore, does not question a hospital governing board's right to require liability coverage of its medical staff, but in sympathy with the authors of both of these resolutions considered the practice open to moral question. Therefore, the Committee submitted a substitute resolution for Resolutions 76-12 and 76-22.

The motion of the Reference Committee to adopt Substitute Resolution 76-12 failed to carry. A motion to refer Resolution 76-12 and 76-22 to the Board of Governors carried.

Resolution 76-12

Hospital Requirement of M.D. Insurance

Everett Shocket, M.D., Delegate

[Not Adopted—Referred to the Board of Governors]

WHEREAS, The well-publicized self-defensive requirement of some Florida Hospitals that each physician carry a specific amount of personal, Professional Liability Insurance imposes a further financial burden on physicians and, therefore, on the patients they serve, and

WHEREAS, Such a requirement for hospital privileges by providing a "honey bucket" may actually encourage, rather than discourage, the proliferation of mischievous legal actions against both physicians and hospital, and

WHEREAS, Such a requirement in no way ensures quality care to our public but, rather simply imposes a "means test" that may actually work to the disadvantage of our patients (public) by excluding from hospital practice the less affluent physicians, therefore be it

RESOLVED, That the FMA as an organization, and the physicians of Florida individually and collectively condemn this abhorent hospital requirement and recommend that hospital appointments be based on professional merit not on any "means test" and, further, urges hospitals' medical staffs to revise (where necessary) medical staff bylaws to exclude such a prerequisite and, where necessary, the militant support of the FMA will be mobilized to assist.

Resolution 76-22

Mandatory Malpractice Insurance Coverage

Volusia County Medical Society

[Not Adopted—Referred to the Board of Governors]

WHEREAS, Most malpractice insurance companies have increased their rates to hospitals that do not require staff physicians to carry malpractice insurance, and

WHEREAS, These hospitals have made it necessary for physicians to carry malpractice insurance in order to obtain staff membership, and

WHEREAS, The difference in the cost of insurance to hospitals per patient per day is small and can readily be passed on to the patient through room rate charges, and

WHEREAS, The cost of malpractice insurance for physicians is large and shows signs of increasing, and

WHEREAS, Most suits against physician arise from incidents brought on by the hospitals and their employees and not the physicians themselves, and

WHEREAS, The physicians frequently then are sued as well as the hospital, and

WHEREAS, In may cases physicians would not be enjoined in such suits if they did not carry malpractice insurance, and

WHEREAS, Many physicians do not choose to carry malpractice insurance and subject themselves to this ever growing miscarriage of justice in which the plaintiff's attorneys and insurance companies reap a vastly unreasonable amount of the insurance premiums, and

WHEREAS, To require physicians to subjugate themselves to such a scheme against their will would violate their individual rights and freedom,

RESOLVED, That the Florida Medical Association protest such hospital practices and vigorously attempt to get its membership to seek changes in those hospital by-laws to eliminate the requirement of malpractice insurance for staff membership.

Resolution 76-13

PRSO 24-Hour Review

Everett Shockett, M.D., Delegate

Reference Committee reviewed Resolution 76-13 and changed the words "continues to find" to "considers" in the first "Resolved".

The motion of the Reference Committee to adopt Resolution 76-13 as changed carried.

Resolution 76-13

PRSO 24-Hour Review

RESOLVED, That the FMA considers 24-hour review in any form, expensive and nonconducive to good patient care and, further be it

RESOLVED, That the FMA advises the physicians of Florida to resist by all legal means 24-hour review procedures including those imposed by PSRO and, further be it

RESOLVED, That the FMA enlists AMA resistance to the PSRO formulated 24-hour reviews.

Resolution 76-16

Third Party Carrier Reimbursement for Tumor Registry Programs

Guy T. Selander, M.D., Delegate

The Chairman of the Reference Committee advised that the Reference Committee had considered Resolution 76-16 and were informed that it is appropriate for the House of Delegates to urge its members to take an action but that committee instruction is the proper task of the Board of Governors. Therefore, the Committee had changed Resolution 76-16 by deleting the words "by instructing its insurance committee to urge" and inserting the words "and urge".

The motion of the Reference Committee to adopt Resolution 76-16 as changed carried.

Resolution 76-16

Third Party Carrier Reimbursement for Tumor Registry Programs

RESOLVED, That the Florida Medical Association further support and endorse the concept of individual hospitals having such a program and urge third-party carriers, be they either government or non-governmental, to recognize and reimburse such institutions providing a tumor registry as part of their patient benefits.

Resolution 76-19

Third Party Carrier Reimbursement for Tumor Registry Programs Dade County Medical Association

The motion of the Reference Committee that Resolution 76-19 be disapproved, as it is identical in intent with the previous Resolution 76-16, carried.

Resolution 76-20

Professional Standards Review Organization Hillsborough County Medical Association

The Chairman of Reference Committee V advised that in testimony heard relating to this Resolution a question was raised as to whether the requirements adopted by the House of Delegates at its Called Meeting in December 1974, and embodied in Resolution 74-CM-1 were specifically binding on foundations for medical care. Reference Committee V received an opinion from the Speaker of the House of Delegates and from the Chairman of the Judicial Council that the 50 percent approved mandate in Resolution 74-CM-1 specifically relates only to component medical societies of the Florida Medical Association. The Committee heard testimony (1) that the Hillsborough County Medical Association has not at this time polled its own membership for approval of PSRO implementation and (2) that the Hillsborough County Medical Association has a related foundation for medical care which is probably favorably disposed to seek PSRO designation. For these reasons, the Reference Committee considered it unnecessary at this time to change the FMA policy adopted by the House of Delegates and embodied in Resolution 74-CM-1.

The Reference Committee recommended disapproval of Resolution 76-20 and the motion carried.

A motion was then made to refer the portion of the Reference Committee's report concerning "opinion from the Speaker of the House of Delegates and from the Chairman of the Judicial Council" back to the Board of Governors for consideration. The motion carried.

Resolution 76-23

Private Aircraft Travel Accident Insurance John C. Kruse, M.D., Delegate

The Reference Committee changed Resolution 76-23 by changing "society business" to "business of the FMA".

Dr. Kruse, sponsor of Resolution 76-23 moved an amendment to add the words "if feasible" after the word "implement." The motion carried. The motion of the Reference Committee to approve Resolution 76-23 as amended, carried.

Resolution 76-23

Private Aircraft Travel Accident Insurance

RESOLVED, That the House of Delegates direct the Board of Governors to investigate and implement, if feasible, accident insurance coverage for members and officers who fly their own or rented aircraft on business of the FMA.

Resolution 76-25

Blue Shield of Florida Charles K. Donegan, Delegate

Reference Committee V heard testimony relating to Resolution 76-25 maintaining that withdrawal of the Florida Medical Association from its present relationship with Blue Shield may well be exactly what parties attempting to alter by legislation the Blue Shield governing board would wish. The Committee also heard testimony that any action by the House of Delegates to separate itself from its relationship with Blue Shield might be misinterpreted. The Committee was informed that the membership of Blue Shield had, prior to our consideration of this resolution, adopted a position of resisting mandated changes in the Blue Shield Board of Directors. The Committee feels that this resolution rather than helping the Blue Shield cause might well work, if interpreted as a threat, to the disadvantage of Blue Shield.

The Reference Committee therefore moved disapproval of this Resolution 76-25. The motion to disapprove carried.

Resolution 76-27

Relative Value Studies Broward County Medical Association

The Reference Committee had considered Resolution 76-27, Relative Value Studies and heard testimony that any further action by our Association in the field of Relative Value Studies might precipitate suit as has happened to some specialty societies. There was also testimony that as of this date no geographically organized multi-disciplinary Relative Value Study has been attacked as fee set-

ting. Several witnesses testified to the value of such studies in bringing order out of chaos both in nomenclature and value determination. The Reference Committee felt that the advantages of continuing to maintain accurate relative value information are significant.

The Reference Committee moved that Resolution 76-27, Relative Value Studies, be disapproved. The motion of the Reference Committee to refer the Resolution to the Board of Governors carried.

Resolution 76-27
Relative Value Studies
Broward County Medical Association
[Not Adopted—Referred to the Board of Governors]

WHEREAS, The Federal Trade Commission has instituted litigation against the American College of Anesthesiologists, and

WHEREAS, Other professional specialty societies have halted use of or referral to Relative Value Studies, and

WHEREAS, Relative Value Studies, Florida Medical Association, 1975, has been issued, it is

RESOLVED, That further studies or references to Florida Medical Association Relative Value Studies; except where currently required by law, cease.

The motion of the Reference Committee to adopt the Report of Reference Committee No. V as amended carried.

Before commencing with the elections, Dr. Emmett Ferguson of Duval County took the floor to commend Dr. James Walker, Duval County, for his excellent job as Secretary and also Dr. Thad Moseley, Duval, for his excellent job as President last year.

Elections

President-Elect

The Speaker opened the floor for nominations for the office of President-Elect of the Association for 1976-1977.

Dr. T. Byron Thames, Orange County, placed in nomination the name of Dr. Louis C. Murray of Orlando.

Dr. Murray's nomination was seconded by Dr. Francis C. Coleman, Hillsborough County; Dr. Gerold L. Schiebler, Alachua County; Dr. Luis Perez, Seminole County; Dr. George S. Palmer, Capital Medical Society; Dr. Walter H. Winchester, Pinellas County; Dr. Curtis W. Cannon, Palm Beach County, Dr. Joseph Von Thron, Brevard County and Dr. Ray E. Murphy of Broward County.

Nominations were closed and a unanimous ballot was cast for Dr. Murray.

Dr. T. Byron Thames and Dr. Clarence M. Gilbert escorted Dr. Murray to the podium.

Dr. Murray: "I appreciate the opportunity you have given me and I will do my level best to justify your faith and trust."



Mrs. Vernon B. Astler, wife of the retiring President, receives his official portrait from incoming President Jack A. MaCris, M.D.



President-Elect Louis C. Murray, M.D., is escorted to the podium by two Orlando colleagues, Clarence A. Gilbert, M.D., (left) and Thomas B. Thames, M.D.



Jack A. MaCris, M.D., addresses the House of Delegates for the first time as President.

Vice President

The floor was opened for nominations for the office of Vice President.

Dr. Charles F. Tate of Dade County placed in nomination the name of Dr. O. William Davenport of Miami.

Dr. Davenport's nomination was seconded by Dr. Thomas F. Regan of Broward County. Dr. Thad Moseley, Duval County, also seconded the nomination of Dr. Davenport and moved that the nominations be closed and that Dr. Davenport be elected by acclamation.

Nominations were closed and Dr. O. William Davenport was elected Vice President by acclamation.

Speaker of the House

The floor was opened for nominations for the office of Speaker of the House.

Dr. Philip B. Phillips of Escambia County placed in nomination the name of Dr. Charles J. Kahn of Pensacola.

Dr. Ralph M. Stephan of Hillsborough County and Dr. C. Burling Roesch of Duval County seconded the nomination of Dr. Kahn.

Nominations were closed and a unanimous ballot was cast for Dr. Kahn.

Vice Speaker

The Speaker recognized Dr. Thomas Weaver of Lake County who made a motion that the By-Laws, which require the vice speaker to be elected from the membership of the House of Delegates, be waived so that the name of Dr. Frederick C. Andrews of Lake County could be placed in nomination for vice speaker. The motion to waive the By-Law carried, and Dr. Weaver nominated Dr. Frederick C. Andrews for Vice Speaker.

Dr. John C. Fletcher of Hillsborough, Dr. Bergon F. Brokaw of Lake County, Dr. Luis Perez of Seminole and Dr. Samuel L. Renfroe of Marion County seconded the nomination of Dr. Frederick C. Andrews of Lake County for vice speaker.

Dr. James L. Borland, Duval County, placed in nomination the name of Dr. Sanford Mullen of Jacksonville.

Dr. Mullen's nomination was seconded by Dr. Rex E. Myers, Hillsborough County; Dr. Pedro Greer, Dade County; Dr. Roy E. Campbell, Putnam County; Dr. William O'Connell, St. Johns County; and Dr. David C. Lane, Broward County.

The votes were counted and the Speaker announced that Dr. Sanford Mullen had been elected Vice Speaker.

Secretary

The floor was opened for nominations for the office of Secretary.

Dr. Karl R. Rolls, Sarasota County, nominated Dr. Robert E. Windom of Sarasota for Secretary.

Dr. Windom's nomination was seconded by Dr. William J. Dean, Pinellas County; Dr. Charles P. Hayes, Duval County; Dr. Dick Van Eldik, Palm Beach County; Dr. Thomas E. McKell, Hillsborough County; Dr. Robert B. Katims, Dade County; and Dr. Calvin W. Martin, DeSoto-Hardee-Glades County.

The nominations were then closed and a unanimous ballot was cast for Dr. Windom.

Treasurer

The Speaker called for nominations for the office of Treasurer.

Dr. John Petrakis of Hillsborough County placed in nomination the name of Dr. Richard S. Hodes of Tampa.

Dr. Hodes' nomination was seconded by Dr. John C. Kruse, Duval County; Dr. Larry Garett, Lee County; Dr. Thomas R. Busard, Manatee County; and Dr. Morris J. LeVine, Pinellas County.

Nominations were closed and a unanimous ballot was cast for Dr. Hodes.

AMA Delegates

The Speaker opened the floor for the election of three AMA delegates for two-year terms beginning January 1, 1977, and expiring December 31, 1978.

The Speaker called for nominations for election of an AMA Delegate to fill the seat of Dr. Holland, who is retiring from Seat No. 3.

Dr. Charles Metzger of Palm Beach County placed in nomination the name of Dr. Vernon B. Astler, Immediate Past President, to fill the vacancy in Seat No. 3.

Dr. Astler's nomination was seconded by Dr. C. Brock Magruder of Orange County, Dr. Henry J. Babers of Alachua County and Dr. Stewart Hagen of Lee County.

Dr. David S. Hubbell of Pinellas County placed in nomination the name of Dr. Charles K. Donegan of St. Petersburg.

Dr. Donegan's nomination was seconded by

Dr. Thomas E. McKell of Hillsborough County.

The nominations were closed, ballots were cast, and the Speaker announced that Dr. Charles K. Donegan had been elected as the AMA Delegate to fill the vacancy in Seat No. 3.

The Speaker called for nominations for election for the position as alternate for Delegate Seat No. 8.

Dr. Harold L. Williamson of Hillsborough County placed in nomination the name of Dr. Frank C. Coleman for re-election as alternate for Seat no. 3.

Dr. Rufus M. Holloway of Orange County and Dr. Yank D. Coble of Duval County seconded the nomination of Dr. Coleman.

Nominations were closed and a unanimous ballot was cast for Dr. Coleman.

The Speaker called for nominations for election of an AMA Delegate for Seat No. 2.

Dr. Clarence Gilbert of Orange County placed in nomination the name of Dr. Samuel M. Day of Jacksonville for re-election.

Dr. Day's nomination was seconded by Dr. Emmet F. Ferguson of Duval County and Dr. J. Gerard Converse of Polk County.

Nominations were closed and a unanimous ballot was cast for Dr. Samuel M. Day for re-election as AMA Delegate for Seat No. 2.

Dr. Richard Dever of Dade County placed in nomination the name of Dr. Jack Q. Cleveland of Coral Gables for re-election as alternate for seat No. 2.

Dr. Cleveland's nomination was seconded by Dr. James J. Schoeck of Orange County.

Nominations were closed and a unanimous ballot was cast for the re-election of Dr. Cleveland as alternate for Seat No. 2.

The Speaker then called for nominations for AMA Delegate for Seat No. 5.

Dr. Victor H. Knight of Hillsborough County placed in nomination the name of Dr. Richard G. Connar for re-election as AMA Delegate for Seat No. 5.

Dr. Connar's nomination was seconded by Dr. Richard Clay of Dade County and Dr. Douglas Murphy of Sarasota County.

Nominations were closed and a unanimous ballot was cast for Dr. Connar for re-election as AMA Delegate for Seat No. 5.

The Speaker then called for nominations as alternate for Seat No. 5.

Dr. Rowland E. Wood of Pinellas County placed in nomination the name of Dr. Vernon B. Astler, Palm Beach County Medical Society.

Dr. Calvin W. Martin, DeSoto-Hardee-Glades County seconded the nomination of Dr. Astler.

Dr. Ray E. Murphy of Broward County placed in nomination the name of Dr. Russell B. Carson of Ft. Lauderdale.

Dr. Carson's nomination was seconded by Dr. W. Dean Steward of Jackson County and Dr. Henry Hardin of Dade County.

The nominations were closed, ballots cast, and the Speaker announced that Dr. Vernon B. Astler had been elected as alternate to Seat No. 5.

Dr. W. Dean Steward then called for a standing ovation for Dr. Francis T. Holland for his services to the Florida Medical Association and his many years as an AMA delegate.

The Delegates elected for terms January 1, 1977 —December 31, 1978 are as follows:

Delegate	Dr. Charles K. Donegan
Alternate	Dr. Frank C. Coleman Seat No. 3
Delegate	Dr. Samuel M. Day
Alternate	Dr. Jack Q. Cleveland Seat No. 2
Delegate	Dr. Richard G. Connar
Alternate	Dr. Vernon B. Astler Seat No. 5

Judicial Council

The Speaker referred the House to the report of the Board of Governors, in which the Board nominated Dr. Joseph H. Davis, District D, to fill the unexpired term of Dr. William E. Straight.

The motion carried to elect Dr. Joseph H. Davis to the Judicial Council to complete a term expiring 1977 from District D.

The Board had made two nominations for the vacancy of a five-year term expiring in 1981. The nominations are Dr. Vincent P. Corso of Miami and Dr. Paul C. Harding of Orlando.

Ballots were cast and the Speaker announced that Dr. Vincent P. Corso of Miami had been elected.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report, and ask for additional nominations from the floor.

The Speaker announced that in addition to the regular four-year terms expiring in District 7, Dr. Knight has also resigned, whose term expires in 1978. Upon nomination from Hillsborough County Medical Association, the Board appointed Dr. J. Robert Qualey to this vacancy for the interim until this election. This vacancy in District 7, expiring in 1978, is also open for nominations from the floor.

There were no other nominations.

Dr. Ralph M. Stephan of Hillsborough County seconded the nomination of Dr. Qualey.

Motion carried to elect Dr. Robert J. Qualey to fill the vacancy in District 7.

Motion carried to elect the nominees submitted by the Board of Governors to the Committee on Membership and Discipline (See Report of Board of Governors, Page 509.)

Dr. MaCris introduced the new Board of Governors and the Council Chairmen.

The Executive Vice President announced that with regard to future annual meetings, that next year's annual meeting was committed to the Americana but all locations after that were tentative and that one area being considered was the Lake Buena Vista area.

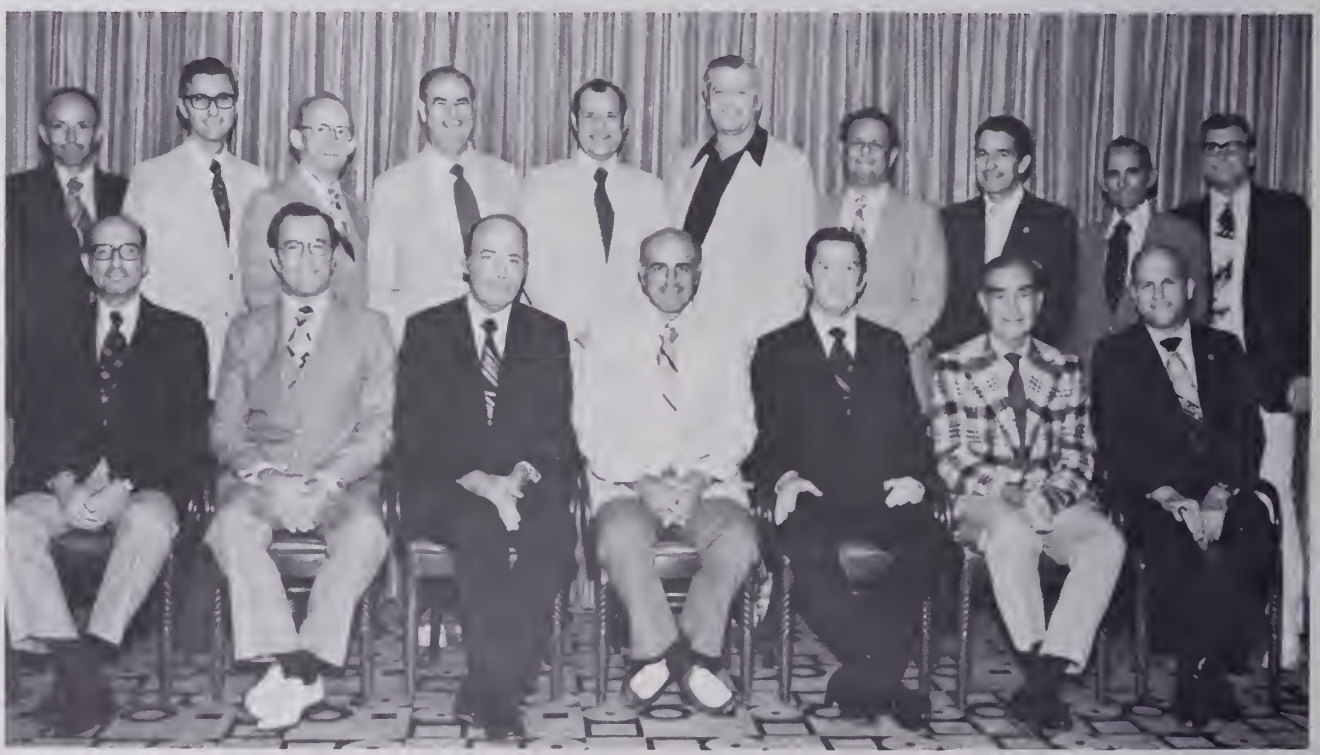
Dr. Robert J. Brennan of Broward County requested that consideration be given to moving the date of the annual meeting from Mother's Day and Dr. Parham advised consideration would be given to this request insofar as it would be possible to work this out with the future hosts of the annual meeting and their schedules.

Dr. MaCris, President, introduced the new Board of Governors and Council Chairman and asked each to stand and be recognized.

Dr. Henry J. Babers, Past President, gave the benediction.

Dr. Babers: "Dear God, please forgive us for our sins; please keep us straight and please help us in the coming year until we meet again."

The 1976 House of Delegates adjourned at 12:25 p.m.



No sooner had the final gavel fallen in the House of Delegates than the new Board of Governors went to work. Front row, left to right: Treasurer Richard S. Hodes, M.D., Tampa; Secretary Robert E. Windom, M.D., Sarasota; President-Elect Louis C. Murray, M.D., Orlando; President Jack A. MaCris, M.D., St. Petersburg; Immediate Past President Vernon B. Astler, M.D., Boynton Beach; Past President Thad Moseley, M.D., Jacksonville; and Thomas B. Thames, M.D., District C. Standing: Norman M. Kenyon, M.D., South Miami, District D; Theodore J. Marshall, M.D., Pensacola, District A; Joseph G. Matthews, M.D., Orlando, Blue Shield; Benjamin M. Cole, M.D., Orlando, Board of Medical Examiners; Donald G. Nikolaus, M.D., Dunedin, District B; Eugene G. Peek, Jr., M.D., Ocala, Department of Health and Rehabilitative Services; House Speaker Charles J. Kahn, M.D., Pensacola; Joseph C. Von Thron, M.D., Cocoa Beach, AMA Delegation; the late Curtis W. Cannon, M.D., West Palm Beach, At Large; and W. Harold Parham, D.H.A., Executive Vice President. Vice President O. William Davenport, M.D., Miami, was absent when picture was made.

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Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

ORGANIZATION

Summary of FMA Board of Governors Meeting, March 20, 1976

The following is a summary of the actions taken by the Board of Governors at its meeting on March 20, 1976, in Boca Raton.

The Board:

BOARD OF MEDICAL EXAMINERS Nominated for consideration by Governor Askew eight physicians for appointment to seats on the Board of Medical Examiners that expire in the summer.

RETIRED PHYSICIANS Went on record as opposing legislation pending in the Legislature to grant Florida licenses without examination to retired physicians from other states.

RELATIVE VALUE STUDIES Approved a joint meeting of the Council on Specialty Medicine and the Committee on Relative Value Studies to review procedures for revising the RVS.

WORKMEN'S COMPENSATION Asked the American Medical News and the Journal of the Florida Medical Association to print a rebuttal to the claim of the United Physicians and Dentists of Florida that it was responsible for achieving this year's increase in the Workmen's Compensation medical and surgical fee schedule.

COUNTY HEALTH DEPARTMENTS Supported substantial increases in state funding for county health departments.

CPR AND LIFE SUPPORT TRAINING Supported broad based educational programs to train the lay public in cardio-pulmonary resuscitation and other medical emergency and self-help techniques; and established guidelines for these programs.

WEST FLORIDA MEDICAL FOUNDATION Officially recognized the West Florida Medical Foundation.

MEDICAID PMUR CONTRACT Asked the Florida Medical Foundation to continue its negotiations with the Department of Health and Rehabilitative Services on a contract to provide peer medical utilization review for Florida's Medicaid program.

MANDATORY CME PROGRAM Directed that members who began their first three-year mandatory continuing medical education cycle on January 1 of 1974 or 1975 must complete 90 hours. Those beginning on January 1, 1976, must earn 150 hours within three years

in view of program changes voted by the House of Delegates on February 1.

MENTAL AND EMOTIONAL DISORDERS Asked the State of Florida to refrain from hiring psychologists and social workers to practice medicine as defined in the Medical Practice Act in the treatment and diagnosis of mental or emotional disorders.

FLORIDA SOCIETY FOR ADMINISTRATIVE MEDICINE Referred back to the Council on Specialty Medicine the application of the Florida Society for Administrative Medicine for FMA recognition as a specialty group.

FLORIDA THORACIC SOCIETY Deferred action on the application of the Florida Thoracic Society for recognition as a specialty group.

PAP SMEARS Urged government and all other third-party payors to consider Pap Smears a necessary and reimbursable medical procedure.

VOLUNTARY HEALTH AGENCIES Renewed for another year FMA recognition of 12 voluntary health agencies; and asked the Chairman of the Committee on Voluntary Health Agencies to conduct a strict re-evaluation of these organizations.

MANDATORY AMA MEMBERSHIP Suggested to the House of Delegates that the matter of mandatory membership in the American Medical Association for FMA members be deferred for one year; and invited county medical societies to comment.

NURSING HOMES Offered the Legislature FMA assistance on problems involving nursing homes; and urged FMA members to assume active roles in the supervision of nursing home care.

The following is a summary of the actions taken by the Board of Governors at its meeting in Hollywood on May 9, 1976:

The Board:

APPOINTMENTS Approved the following appointments: Joseph C. Von Thron, M.D., Cocoa Beach, AMA Delegate on the Board of Governors; Eugene G. Peek, M.D., Ocala (Department of Health and Rehabilitative Services), Joseph G. Matthews, M.D., Orlando (Blue Shield of Florida), and Benjamin M. Cole, M.D., Orlando (Board of Medical Examiners) as advisory members of the Board of Governors; and Vernon B. Astler, M.D., Boynton Beach, Public Relations Officer.

COMMITTEE FOR PRESS, RADIO & TV RELATIONS Commended the year-old Committee on Press, Radio and TV Relations, then dissolved it.

COMMITTEE ON STATE LEGISLATION Deferred appointments to the Committee on State Legislation until after adjournment of the 1976 Legislature.

MEDICAID Referred to President Jack A. MaCris, M.D., a proposal for further follow-up to the Department of Health and Rehabilitative Services regarding the release of the names of the 10 physicians who have received the most payments under the Medicaid Program.

FLORIDA PHYSICIANS ASSOCIATION Approved the election of David T. Overbey, Jr., M.D., St. Petersburg, as President of the Florida Physicians Association, and other new officers elected by the FPA Board.

BC-BS/FMIT Approved a carrier contract between Blue Cross-Blue Shield and the Florida Medical Insurance Trust.

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SPECIAL ARTICLES

Physicians' Rights to Hospital Privileges

Joan L. Wollin, J.D.

Abstract: Florida statutes give the control of medical decisions and the responsibility for medical staff selection and delineation of privileges to the hospital's organized medical staff. A misinterpretation of the Darling decision is often used by hospital governing boards to exert unwarranted control over the physicians on the staff. Although the physician is entitled to procedural due process and judicial review, it is recommended that the medical staff have its own legal advisor to ensure an equal bargaining position.

Traditionally, a physician's membership on the medical staff of a hospital has been viewed as a privilege granted by the individual hospital rather than an absolute right. The constitutional, statutory, judicial and extralegal factors affecting the rights of a physician to practice his profession as a member of the hospital staff will be examined, admittedly from the point of view of the physicians' advocate.

The related problems of rights of osteopathic physicians and other practitioners, salaried medical house staff (interns and residents), teachers in university hospitals, Veterans Administration staff, military staff, and full-time physicians in federal and other governmental hospitals are beyond the scope of this analysis, which is primarily concerned with the medical staff privileges of the physicians in the private practice of medicine.

Procedural Due Process

For the physician, having medical staff privileges is of prime importance. In **Foster v. Mobile County Hospital Board** the court stated:

> A physician or surgeon who is not permitted to practice his profession in a hospital is, as a practical matter, denied the right to fully practice his profession. Much of what a physician or surgeon must do in this day of advanced medical technology can only be performed in a hospital.[1]

Without hospital privileges a physician would become a virtual referral agent for other doctors who do have such privileges, since any patient requiring hospitalization would have to be asked to see another doctor. If a doctor's privileges are revoked, he stands to lose a substantial part of his practice and thus a large portion of its financial rewards. Once dismissed he will find it more difficult to obtain privileges in another hospital, his professional standing will deteriorate, and he will lose the valuable experience of close association with other physicians.[2]

In addition to those indirect penalties, a physician who loses his hospital privileges may also be deprived of his license to practice medicine. All disciplinary action including removal or suspension from the hospital staff must be reported to the Florida Board of Medical Examiners.[3] The "Florida Medical Malpractice Reform Act" further provides in part:

> §458. 1201(1) The board shall have authority to deny application for a license or to discipline a physician . . . who after hearing has been adjudged unqualified or guilty of . . . (m) immoral or unprofessional conduct, incompetence, negligence, or willful misconduct . . . (o) being found liable for medical malpractice . . . (p) being removed or suspended or having disciplinary action taken by his peers within any professional medical association, society, professional standards review organization . . . whether or not such . . . body is local, regional, state, national or international in scope, or by being disciplined by a licensed hospital or medical staff for immoral or unprofessional conduct or willful misconduct or negligence.[4]

Most forms for application for medical staff privileges inquire about previous hospital membership records and history. The applicant usually obtains a somewhat standard form from the office of the hospital administrator which asks for a summary

Mrs. Wollin has a law degree from the University of Florida and is the wife of Ernest Wollin, M.D., President of the Lake County Medical Society, Leesburg.

of his medical education, previous hospital affiliations, membership in professional societies, certifications, continuing medical education, licenses, medical references, liability insurance, and privileges desired. In addition, the form inquires if the applicant's license to practice medicine, membership on a medical staff, hospital privileges, narcotics registration or membership in a medical organization has ever been denied, suspended, diminished, revoked or not renewed, or if he has ever been the subject of disciplinary action.

Thus denial, revocation, or restriction of a physician's membership in the medical staff of a hospital can result in serious consequences to his medical career which may haunt him all his professional life. If is therefore imperative that physicians' privileges not be denied arbitrarily. The decision to deny them must not violate due process or equal protection.[5] Fortunately, in Florida, hospital licensing statutes and regulations and Joint Commission on Accreditation of Hospitals standards require hospital bylaws to provide hearing procedures when medical staff privileges are denied.[6]

Courts are reluctant to review the internal affairs of a hospital until all administrative procedures have been exhausted.[7] Care should be taken that the elements of a fair hearing are present. These would include adequate notice, opportunity to be heard, and an impartial decision maker. In **Christhilf v. Annapolis Emergency Hospital Association**[8] a physician's hospital privileges were not renewed by the board of managers after a recommendation by the joint conference committee. Dr. Christhilf was not notified of the meetings and the court ruled that he was denied procedural due process of the Fourteenth Amendment of the United States Constitution and in violation of 42 U.S.C.A. §1983.

Many courts recognize that the hospital-physician relationship is contractual. The bylaws are considered contract terms and any provisions not followed, especially in the removal of privileges without a hearing, would be considered a breach of contract.[9]

The court in **Wyatt v. Tahoe Forest Hospital District**[10] held that an unsuccessful applicant for staff membership was entitled to a hearing to determine whether or not his qualifications met the requirements established by law. The court noted further that a physician who was not permitted to practice in a hospital was, as a practical matter, denied the right to practice his profession fully.

In **Harron v. United Hospital Center**[11] the Federal District Court held that evidence established that a contract granting the defendant radiologist sole responsibility for all initial x-ray interpretations performed in the open-staff radiology department of the hospital had the effect of reducing the medical staff privileges of the plaintiff. It held further that this reduction of privileges without affording a hearing did not comport with the requirements of the hospital bylaws and that the plaintiff was entitled to the protection of the Fourteenth Amendment warranting injunctive relief which was granted.

Although there are no concrete guidelines defining procedural due process, the consensus of the courts is that the specific hearing provisions of the bylaws be met. When these administrative remedies are exhausted, judicial relief is available to review physicians' rights to hospital staff privileges.

Public and Private Hospital Dichotomy

In the recent past, any rights to membership on the medical staff of hospitals depended upon the threshold distinction between public and private hospitals. The distinguishing characteristics were based on the hospital's financial structure which, in turn, affected its discretionary powers. The courts were especially reluctant to interfere in the internal affairs of a hospital's administration.

Historically, tax exempt status, receipt of tax revenues from state or local government, or funding through the Hill-Burton program did not automatically convert a voluntary, private hospital into a government hospital. Several recent cases, however, have been accepted within federal court jurisdictions merely on the basis of receipt of Hill-Burton funds which was sufficient to be deemed state involvement of private hospitals.[12]

Thus there is now an evolving trend for judicial consideration balancing the rights of physicians to practice their profession, the hospital's needs, and the public interest in the quality of medical care. Many courts are shedding their prior reluctance to scrutinize medical staff exclusions not only to see that the public interest is protected, but also to insure that the rights of the individual practitioner are not capriciously violated.[13] Such considerations take place whether the hospital is deemed to be public or private. The differences are being extinguished.

Although many courts have tried to resolve the problem of who has the ultimate authority to select the members of the medical staff, the statutory laws of Florida delegate the duty to the organized medical staff for all licensed hospitals whether public or private.

Statutory Hospital Licensing and Regulations

In order for hospitals to operate in Florida they must be licensed by law. Florida Statutes §§395.10 and 395-11 provide for an advisory council headed by the Director of the Division of Health whose responsibilities and duties include those of developing rules, regulations and standards. Chapter 10D-28 of the Rules of the Department of Health and Rehabilitative Services includes specific requirements pertinent to medical staff privileges.

Section 10D-28.08 defines the relationship between the "Governing Authority" of the hospital and the medical staff:

> The hospital shall have an effective governing authority responsible for the legal and moral conduct of the hospital as a functioning institution. . . . Arrangements between the administration and the physicians providing care for patients in the hospital are such as **to permit the practice of medicine without any improper influence, direction or impediment.** (Emphasis supplied.) (1)(a) . . . Physicians who are members of the medical staff shall be eligible for, and **should** be included in, full membership on hospital governing bodies and their action committees in the same manner as other knowledgeable and effective individuals . . . (1)(f) . . . No action on appointment, reappointment or dismissal shall be taken without prior referral to the medical staff for their recommendation . . . The governing body shall only appoint members of the medical staff as recommended by the medical staff . . . The written by-laws, rules, and regulations of the governing authority of the hospital shall include a procedure for hearing and appeal on the appointment, reappointment or dismissal of members of the medical staff.

Section 10D-28.10 sets forth the responsibilities of the Medical Staff:

> Each hospital shall have a medical staff organized under written by-laws approved by the governing authority and responsible to the governing authority of the hospital for the quality of all medical care provided to patients in the hospital and for the ethical and professional practices of its members. . . . (2)(d) (A committee shall) review all applications for appointment and annual appointment to all categories of staff, and recommendations on each to the governing authority, including delineation of privileges to be granted in each case, and right of hearing and appeal. Recommendation to the governing body for withdrawal of any privileges of a member of the medical staff or dismissal from the medical staff will be made only after a thorough investigation by the **medical staff** or a committee thereof, with the subject member being given the right of hearing before the medical staff or committee thereof.

The licensing rules, especially 10D-28.08(1)(f) and 10D-28.10(2)(d), reiterate the express authority of the medical staff of a hospital to make decisions on initial, renewed, or revoked appointments and to delineate the specific privileges of the medical practitioner. In fact, the rule emphasized without equivocation that "the governing body **shall** only appoint members of the medical staff as recommended by the medical staff."[14]

In the 1975 regular session of the Florida legislature, "The Medical Malpractice Reform Act" was passed to be effective on May 20, 1975.[15] Section 395.18 includes an "Internal Risk Management Program" for hospitals having in excess of 300 beds. Subsection (3) provides for the analysis of patient grievances which relate to patient care and the quality of medical services. The program can be carried out either through the hospital administration, the hospital board of directors, or by the medical staff **in a manner deemed appropriate.** (Emphasis supplied). Since the implementation of this program is written in the alternative, the logical interpretation, consistent with the other provisions of this section, is that the "manner deemed appropriate" would be for a medical committee to analyze any grievances which relate to medical services.

Section 395.065 entitled "Hospital Disciplinary Powers" is added:[16]

> (1) The medical staff of any hospital licensed pursuant to Chapter 395, Florida Statutes, is authorized to suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause. . . . Provided, however, that the procedures for such actions shall comply with the standards outlined by the Joint Committee of Accreditation of Hospitals and the Principles of Participation in the Federal Health Insurance Program for the Aged.

Not only is the responsibility of the hospital's medical staff reaffirmed in the recent legislative action, but also reference is made to the standards set by extralegal agencies.

The J.C.A.H., endorsed by Florida statutory law, again places the responsibility for staff privileges for all licensed and accredited hospitals in Florida to be that of the organized medical staff, through self-government, medical care evaluation, and peer review.[17]

Darling Revisited

Through the propaganda put forth by the American Hospital Association and perpetuated by self-serving administrators and other lay hospital governing authorities, the landmark case of **Darling v. Charleston Community Memorial Hospital**[18] is often quoted, but more often misquoted to justify lay control over physicians on the attending staff of a hospital. The erroneous interpretation is that the hospital is jointly responsible for any act of malpractice physicians may commit in the delivery of medical services within the hospital. With this base, the theory holds that if the hospital is responsible for the attending physician's mistakes, it has the right to supervise and direct his services. This is not what the **Darling** case holds.[19]

The facts are simple. Darling received negligent care in the treatment of a broken leg. He did not select the physician who was on emergency call. The court held the hospital responsible for the physician's negligent treatment; first, because his services were provided by the hospital and, secondly, because the facts of the case show and the court found that the nursing care was negligent. The nurses failed to call attention to what was obviously a gangrenous condition as evidenced by the continuing pain and foul odor that filled the room. In essence, the hospital was negligent in its own right.[20]

Darling is an Illinois case. Subsequent Illinois cases have interpreted its ruling narrowly. In **Lundahl v. Rockford Memorial Hospital** the court stated:[21]

> The plaintiffs cite the **Darling** case in support of their contention that the hospital was negligent in its failure to require consultation between Dr. Paynter and the members of its staff. In the **Darling** case, however, the treating physician was placed by the hospital on emergency duty and subject to its supervision. Dr. Paynter was not employed by the hospital, was not an agent of it, and not subject to its supervision. The decision to give a laxative or enema is a medical question . . . and was entirely within the discretion of the treating physician, not the hospital.

In 1973, the Illinois court referred again to the **Darling** decision in **Collins v. Westlake Community Hospital:**[22]

> In **Darling,** the plaintiff sustained a broken leg and was treated by one Dr. Alexander, the attending physician . . . was not a specialist in orthopedics. . . . The evidence . . . showed not only grossly improper medical treatment by the attending physician but also a continuing and total fallure by the hospital staff to recognize, report and react to a multitude of glaring obvious signals. . . .

The narrow interpretation of a hospital's liability is not only in Illinois but also in the federal courts. In **Haven v. Randolph**[23] the court declared that a hospital is liable for the acts of a physician only if he is employed by the hospital and/or acts as an agent for the hospital. A private pediatrician whose patient suffered injury during a procedure performed in the hospital was not an agent of the hospital where he was exercising independent and professional skill and judgment. If further held that a hospital is not liable with respect to injuries resulting from treatment pursuant to the orders of private physicians.

Many community hospitals require the active attending staff to rotate on call to donate their services for emergency room duty regardless of the specialty or expertise of the physician. A radiologist could be required to do a shoulder reduction or a dermatologist may have to deliver a baby. The real meaning of the **Darling** decision is that hospitals should staff emergency rooms with physicians qualified in such care and should not require through their regulations that physicians untrained in emergency room specialties serve in that capacity.

In any interpretation, Florida statutes expressly give the control of medical decisions and the responsibility for medical staff selection directly to the organized medical staff of all licensed and accredited hospitals. It is the duty of the physician's advocate to remind the Florida courts of the existence of these laws, which is often overlooked either by inadvertence or design.

Remedies

Various causes of action are available for judicial review of hospital staff privileges. The usual remedy sought by a doctor who wishes to continue his practice in the hospital is injunctive relief. A temporary restraining order against the hospital should be considered pending judicial decision on the merits. In **Ware v. Benedikt,**[24] an injunction was requested in the denial of initial staff privileges. A recent case involved a civil rights action by a radiologist against a hospital, its board of directors, and another radiologist. Injunctive relief arising out of alleged reduction of his medical staff privileges was granted.[25]

Although injunctions are most beneficial to the physician seeking hospital privileges, occasionally suits are brought for damages. In **Cowan v. Gibson**[26] an action alleging damages was brought on the theory of interference with business. A California court in **Willis v. Santa Ana Community Hospital Association**[27] after finding that the plaintiff's credentials were in order, held that a cause of action was stated when it was "alleged that a physician of highest qualifications is denied access to necessary hosptial facilities as the result of a conspiracy designed to restrain competition and deprived him of his practice in order to benefit competing members of the conspiracy."

The new "Medical Malpractice Reform Act" provisions under §395.065 makes the future of any judicial remedy uncertain in Florida. Specifically, the medical staff of any hospital is authorized to suspend, deny, revoke, or curtail the staff privileges of any staff member for good cause provided that the procedures for such actions shall comply with due process requirements of the J.C.A.H.

Subsection (2)[28] states:

> There shall be no liability on the part of and no cause of action of any nature shall arise against any hospital, disciplinary body, its agents or employees for any action taken in good faith and without malice in carrying out the provisions of this act.

Immunity statutes are seldom upheld since they deny access to the courts. This law will have to be tested to determine whether it is a violation of the constitutional right to due process, equal protection, and judicial review.

Conclusion

Unfortunately, there is usually an adversary relationship between the governing body of a hospital and the medical staff. This can be explained by their different perspectives in medical care. The hospital administration has the responsibility for the financial and physical components of the facilities while the medical staff has the primary duty for the treatment of patients. Boards of directors and their administrative employees often view physicians as servants of the hospital rather than the contrary. In order for physicians to exert their influence so that their patients will best be served it is necssary for the medical staff to organize into a united team. It must be made obvious that physicians are the real customers of hospitals. They admit patients. If administrators are unresponsive to their requests, physicians should seek hospital privileges at more than one facility sc that there is a choice for the best place for the care of individual patients.

Thus hospital privileges are not only important for physicians but ultimately for their patients as well. The medical staff must become more influential in the operation of the hospital. The lawyer for the American Medical Association points out that in physician-hospital disputes, the medical staff must have a comparable team of experts to those of the hospital.[29] She states further: "Hospitals have governing boards of businessmen, trained administrators, and highly qualified attorneys who guide the hospital's dealings with the medical staff."[30] Individual physicians consult their attorneys after they are involved in some dispute. It would be wise for medical staffs to have their own consulting attorneys to advise them of their legal rights to prevent damaging litigation and to put the medical staffs on an equal level with the administration. It will be a start toward protecting the legal rights of physicians to practice their profession without undue interference from laymen, all for the benefit of the patient.

FOOTNOTES

1. 384 F. Supp. 194 (D.C. W. Va. 1974)
2. Note, Denial of Hospital Staff Privileges; Hearing and Judicial Review, 56 Iowa L. Rev. 1351-2 (1971).
3. Fla. Laws 1975, Ch. 75-9, to be codified as Fla. Stat. § 458. 1201.
4. Id.
5. Sussman v. Overlook Hosp. Ass'n., 92 N.J. Super. 163, 175, 222 A. 2d 530, 536 (1966), aff'd, 95 N.J. Super. 418, 231 A.2d 389 (1967).
6. See text accompanying note 14 infra; See also Fla. Laws 1975, Ch. 75-9, to be codified as Fla. Stat. § 395.065.
7. Citta v. Delaware Valley Hosp., 313 F. Supp. 301 (E.D. Pa. 1970).
8. 496 F. 2d. 174 (4th Cir. 1974).
9. Note, The Physicians Right to Hospital Membership: The Public-Private Dichotomy, 1966 Wash. U.L.Q. 485, 494.
10. 174 Cal. App. 2d 709, 345 P. 2d 93 (1959).
11. 384 F.Supp. 194 (D.C. W. Va. 1974).
12. Citta v. Delaware Valley Hosp., 313 F.Supp. 301 (D.C. Pa. 1970); Christhilf v. Annapolis Emergency Hosp. Assn., 496 F. 2d 174 (4th Cir. 1974); Harron v. United Hosp. Center, 324 F.Supp. 194 (D.C. W. Va. 1974).
13. Note, Selection of Hospital Staff Members, 40 Cinn. L. Rev. 797-8 (1971).
14. Rules, Dept. Health and Rehabilitative Services, Div. of Health, Ch. 10D-28 (Revised, Mar. 19, 1972); repromulgated, Jan. 1, 1975.
15. Fla. Laws 1975, Ch. 75-9, to be codified as Fla. Stat. § 395.18.
16. Id. § 395.065.
17. Joint Commission Accreditation Hospitals, Accreditation Manual for Hospitals (Chicago, 1973), "Governing Body and Management: Standards VII, IX & X": "Medical Staff: Standards I, II, III, IV, & VII": Appendix II (July, 1973) "Peer Review"; "Utilization Review".
18. 33 Ill. 2d 326, 211 N.E. 2d 253 (1965), cert. denied, 383 U.S. 946 (1966).
19. Anderson, Hospital Governing Board and Medical Staff Relationships, 67 J. Tenn. Med. Assn. 573, 575, (1974).
20. Id.
21. 93 Ill. App.2d 461, 235 N.E. 2d 671, 674 (1970).
22. 12 Ill. App. 3d 847, 299 N.E. 2d 326, 329 (1973).
23. 342 F. Supp. 528 (D.C. 1972).
24. 225 Ark. 185, 280 S.W. 2d 234 (1955).
25. 384 F. Supp. 194 (D.C. W. Va. 1974).
26. 392 S.W. 2d (Mo. 1965).
27. 58 Cal. 2d 806, 376 P. 2d 568 (1962).
28. Fla. Laws 1975, Ch. 75-9, to be codified as Fla. Stat. § 395.065.
29. Anderson, Hospital Governing Board and Medical Staff Relationships, 67 J. Tenn. Med. Ass'n. 573, 578 (1974).
30. Id.

This article is an abridgement of a longer paper and deleted references are available from the author upon request.

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FLORIDA MEDICAL FOUNDATION RESEARCH GRANT APPLICATIONS ACCEPTED UNTIL OCTOBER 30

The Florida Medical Foundation Committee on Research will accept until October 30 applications for 1976-77 research grants.

Applications and other information may be obtained by contacting: J. Lee Dockery, M.D., Chairman, Committee on Research, Florida Medical Foundation, P. O. Box 2411, Jacksonville 32203.

Recipients will be announced early in 1977.

The Real World for Doctors

Richard S. Hodes, M.D.

I feel honored to have been asked to address your class. I am very much aware of this unique program and have publicly applauded the efforts of those persons involved in conceiving and carrying out the PIMS concept. I especially admire the extraordinary cooperation of the three cooperating universities—something you don't see enough of in state government. You have had the fortunate experience of going through a model program.

Since you will soon be entering the next level of your medical education experience, I wish to speak to you tonight of the real world for doctors—a gentle reminder while you continue your training throughout the next three or four years. I will mention some of the pitfalls, exclusions, benefits and expectations that you might be faced with once you begin to practice medicine in the real world.

In order for you to understand or take seriously my perceptions, perhaps I should quickly review some of my experiences over the past decade. I have been involved in the state legislative process for 11 years. During that time, I served for many years as chairman of a house committee whose responsibilities dealt with health and social service policy making. I have also been involved as a member of a national collection of state legislators—the National Conference of State Legislators—whose purpose has been to attempt to influence congress and the federal bureaucracy as to the needs of state government. My responsibility in this group has been in the area of human resources. We have recently put together a coalition of associations and persons interested in the question of national health insurance and have held hearings throughout the United States. We have heard testimony presented by interested parties and state government officials regarding this looming and pressing concept of national health care.

I have undergone boring presentations, numerous trips, long meetings, harried pressures, unreadable or unusable legislative bills, and faced the ever pressing streams of persons who pass through the political process while continuing to practice medicine. I only review this laundry list in order to establish my credibility to you before entering the real world for the next 20 or 30 minutes.

Taking all these experiences into consideration, I have come to the conclusion—a Hodes law—"the more you legislate or regulate the reduction of the cost of health care—or attempt to control its quality—the more likely you are to increase the cost of health care and decrease the quality." This has certainly been an obsession lately with lawmakers and HEW administrators in attempting to legislate or regulate cost and quality controls in the health care field.

Really the obsession is about 15 years old, but it all started earlier with the development of the "blues" (Blue Cross and Blue Shield)—all for a worthy purpose, nonprofit and well regulated. Following the development of the "blues," the provider began to be regulated. Remember you may be a doctor but to the bureaucrat and the lawmaker you are a provider. Fee levels were set, procedure code numbers were established and the paperwork costs and administrative costs started piling on top of the fees and charges.

Then came Medicare designed ostensibly to care for the uncared-for elderly, but, incidentally, and perhaps more, the reason to bail out private and Union retirement plans that couldn't deliver on health care commitments. Cost control in Medicare began to throw the burden on the non-Medicare covered sick who had to make up the deficit created by lowering the cost payments to providers, hospitals and others. This created a higher profile of charges which then cranked into the system and escalated health costs down the line. Then came Medicaid with a similar tale with the lowest end of the economic scale as the recipient and results a little worse than Medicare as utilization shot up and an overburdened system of urban clinics and rural practitioners that treated the poor in the past could only reduce service quality.

This speech was delivered on May 27, 1976 to the graduating class of PIMS (Program in Medical Sciences), Florida State University, Tallahassee.

Dr. Hodes is Treasurer of the Florida Medical Association and a Representative in the Florida Legislature.

Now finally the PSRO and the health service agency, both federal creations with unpredictable effects. PSRO's are professional service review organizations which are supposed to govern quality of care. By what means and at what cost remains to be seen. All the money spent so far has been on paperwork, politics and procrastination. Health service agencies are the latest contribution to the morass of health administrative confusion. Even the law requires imagination to read let alone interpret. Essentially HSA's are designed to prevent over supply of hospital capacity which by some quirk of economic logic raises costs. That quirk is the Medicare system of determining costs, not the market place. Medicare will establish as a recognized cost the cost of keeping empty beds. To restrict the number of empty beds, HSA's must issue a certificate of need before new hospital space can be built. It has been only a very few years since Hill-Burton was giving away tens of millions of tax dollars to develop new hospitals. Hill-Burton contributed to surplus beds. Medicare raised everybody's health costs by paying for them and now HSA's are going to limit new beds. I wonder how it would have worked out without Hill-Burton and hospitals having to bid for the Medicare patients.

A development that has gone hand in hand with these controls has been the federalization and the commercialization of hospitals. There has been a marked decline in new church/nonprofit or local public hospitals, these having been replaced by either commercial hospitals operating for profit or local public hospitals operating entirely in a federalized manner as a response to requirements and regulations developed by the Medicare program—with the federal determinations of expansions—and the upcoming and recent regulations involving generic equivalency requirements regarding drugs. Doctors are facing in the future the concept of PSRO's as well as present day requirements regarding hospital utilization.

There have been areas of neglect in medicine—public health, nutrition and the environment—important areas in which medicine and medical research could have made a great deal of difference in raising the level of the quality of life in America.

I feel sad about a development which has occurred over the past 50 to 60 years—and that is that nobody wants to talk about public health anymore. Ever since the last great influenza epidemic following World War I and the advances of vaccines, innoculations and antibiotics brought about the decline of communicable diseases, the public and the professions considered public health no longer a problem. I wonder what would happen if there sprung forth an antibiotic resistance strain of bubonic plague?

Years ago public health provided the stage for early medical heroes—and those days and those heroes have all but disappeared. Somewhere along the line the commitment for preventive medicine and public health gave way to the determination that—there was no payoff in public health; that the public should or could not be expected to pay for public health. The preventive aspects were put on the backburner and the emphasis was shifted to the treating of sick folks. The public health concept gave way to the "healers." In the changing life styles of the mid twentieth century, it became more attractive to patch up a heart than to really prove ways of preventing the necessity for the patchup.

The melting away of public health concerns—also involves other areas such as nutrition and the environment. Writers or researchers venturing into the field of nutrition are either thought of as the lunatic fringe in quasi-medical literature or appear in the third lead story in cosmopolitan. The health environmentalists have only shown success in one area—that is the ability to create public awareness of cigarette smoking even though sales continued to increase. This has been the only obvious pathogenic environmental agent pushed out in the cold light of day for understanding. In daily life we are assaulted by lead, pesticides, aerosols, and atmospheric sulfa oxides. The only time we can sue for environmental hazards is when we can identify a culprit—as for example — a Corvair collapsing on its unfortunate victim. But, consumer protection in the general public health area is given little attention in a cure and nostrum oriented society.

Another reality to be faced is medical society politics. The root of resistance of organized medicine to participate in politics has shrivelled. Today survival seems to rest on the ability of medicine to deal with the surrounding political society. Medicine has finally joined other interest groups in hiring a vast core of professional hirelings who operate in the shadows of the legislative and bureaucratic hallways as a part of the total collection of the American decision makers.

Medicine, in order to survive as a field as it has been defined in the past, has had to structure a political arm which is involved in supporting candidates, and key lobbyists, entertaining politicians and carrying out vast public relations campaigns. While the price is high, it is cheaper to do this than have

our place in American society erroded as a result of the commercial ambitions of other health and non-health professionals.

On a daily basis legislative bodies in Washington and state houses are assaulted by a barrage of propaganda and legislative proposals designed to legislate respectability. These are pushed by a vast army of psuedo professionals who seek to get a piece of the medical action by creating a license to perform after a limited amount of training — that which you will spend twenty-three years of your life learning and the rest of your life re-learning.

A sizeable portion of your future earnings will be drawn from you to build a barrier against the barrage in the legislative hallways. Another chunk of your income will go toward protecting yourself from the ravages of the tort liability system which the mistakes of your colleages and the greed of the society will bring down upon your head.

Forget for a moment the harsh picture I have just painted. In a softer light, I would like to end up by saying as a doctor you will love the majority of people you practice for, and you will love the majority of people you practice with. I hope that which I am telling you here tonight will constitute the final expurgation of the venom that you feel inclined to carry with you as the truisms which I've expressed become reality in the future.

Remember that it's still the queen of the professions and that you are going to be wearing the uniform that is easily identified and readily soiled. Keep it clean. Personally, it's something I'm glad I've worn, and for all of my enthusiasm for public life, I still have no plans to ever trade my medicine for any other role no matter how prominent or popular.

▶ Dr. Hodes, 238 East Davis Boulevard, Tampa 33606.

Intussusception

On December 13, 1808, Thomas Blizzard, Surgeon to the London Hospital, America-Square, read a paper at the Medical and Chirurgical Society of London relating the case of a five month old child he had attended.

> ". . . he was seized with vomiting, accompanied with constipation and other signs of disordered functions of the bowels. There were, at first, some small discharges of mucus by the anus; but, after Monday, the discharges, which were frequent, were principally of blood. The abdomen was tense, and on the left side, there appeared a tumour, about the size of an egg. A hiccoughing commenced on the Tuesday, and continued until death. . . .
>
> On dissection it appeared that the tumour on the left side was produced by an intus-susception; about six inches of the intestinum ile, the coecum, with its appendix, the ascending colon, and transverse flexure, being contained in the sigmoid flexure of the colon, extending into a state of complete strangulation, and perfectly black."

This is clear clinical and pathologic description of intussusception. — Ronald D. Greenwood, M.D., Boston, Massachusetts.

Reference

Blizzard, T. A.: A Case of Intus-susception, with remarks, Medico-Chirurgical Transactions 1:169-174, 1809.

Acknowledgement: I am indebted to the Francis A. Countway Library of Medicine, Harvard Medical School for use of historical materials.



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EDITORIAL

Acute Rheumatic Fever and Rheumatic Heart Disease

"Doubt is not a pleasant condition, but certainty is an absurd one." **Voltaire** (1694-1778)

Although Voltaire does not practice medicine in the twentieth century, his comment unfortunately remains relevant to the diagnosis of certain human ailments. Among the common medical disorders for which a single definitive diagnostic test is not yet available are acute rheumatic fever and rheumatic heart disease. The situation today still resembles that mentioned by Sir William Osler in the first edition of his famous textbook of medicine in 1892: "Practically, the recognition of acute rheumatism is very easy; but there are several affections which, in some particulars, closely resemble it."[1]

Despite the pioneer work of T. Duckett Jones, which culminated in 1944 in the formulation of what are now referred to as the Jones Criteria for the diagnosis of acute rheumatic fever[2], doubt frequently exists regarding the accuracy of diagnosis. Evidence that the physicians of Florida are aware of these diagnostic difficulties was obtained from a recent survey performed by the Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease. In late 1975, the Task Force surveyed by mail 4,251 primary care physicians (pediatricians, internists, family practitioners) in Florida, asking each to respond to a questionnaire. Replies were received from 443 physicians, representing a return of 10.4%. Ninety-three per cent of respondents indicated that their practice includes patients with a history or diagnosis of rheumatic fever or rheumatic heart disease. Of great interest was the response to the following query: "If so, is there some uncertainty about the accuracy of that history or diagnosis in some cases?" Eighty-two percent of the physicians replied in the affirmative. This response appears to indicate that a significant number of Florida physicians clearly recognize that it may be quite difficult in some cases to establish firmly whether an individual is or is not rheumatic. The importance of being sure, of course, relates both to the need to prescribe prophylaxis against recurrent streptococcal infections in rheumatic individuals and to the advisability of discontinuing prophylaxis for those who are not rheumatic.

The Task Force also queried the physicians regarding the usefulness of a mechanism to assist both in establishing the diagnosis of rheumatic fever and rheumatic heart disease and in the "delabelling" of individuals who may have been considered erroneously to be rheumatic patients. When they were asked "Do you think that data review of problem cases by a panel of experts would be helpful to you or to the patient?", 62% of responding Florida physicians replied yes, 36% no, and 2% were uncertain. When asked "Would you make use of such a panel of experts in evaluating the accuracy of the diagnosis of rheumatic fever and rheumatic heart disease in selected problem cases?", 68% replied yes, 28% no, and 4% were undecided. These replies suggested to the Task Force on Rheumatic Fever and Rheumatic Heart Disease that a mechanism could be established to assist in diagnosis and in "delabelling" individual patients at the request of their private physicians. The availability of new serologic,[3] radiologic,[4] and echocardiographic[5] tools to improve the accuracy of diagnosis makes such assistance more feasible and more realistic than previously.

That rheumatic fever and rheumatic heart disease are not relics of the past but remain significant medical problems is apparent from the experience at several hospitals in Florida in recent years. Tamer's review of acute rheumatic fever diagnosed at Jackson Memorial Hospital in Miami during 1967-1971[6] yielded 98 cases in 95 patients, who ranged in age from five to 48 years. Fifty-four episodes were associated with cardiac involvement, and three children died. Comparable statistics have been

compiled at University Hospital in Jacksonville[7] and at the Shands Teaching Hospital, Gainesville. Thus, despite the lack of accurate state-wide incidence statistics for this disorder, it is clear that substantial numbers of cases of acute rheumatic fever continue to occur in Florida.

The response of the physicians surveyed indicates that there exists general awareness of the diagnostic difficulties encountered in this field. The Florida Task Force on Rheumatic Fever and Rheumatic Heart Disease is committed to the establishment of mechanisms which may, upon physician request, contribute to lessening the degree of uncertainty concerning these diagnoses. Thus, it is hoped that the "unpleasant doubt" which exists for many patients regarding the diagnosis of these maladies may also be diminished.

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References

1. Osler, W.: The Principles and Practice of Medicine, Appleton and Co., New York, 1892, p. 275.
2. Jones, TD: Diagnosis of Rheumatic Fever, JAMA 126:481-4, 1944.
3. Shulman, ST, Ayoub EM, Victorica BE, Gessner IH, Tamer DF, and Hernandez FA: Differences in Antibody Response to Streptococcal Antigens in Children with Rheumatic and Non-rheumatic Mitral Valve Disease, Circulation 50:1244-1251, 1974.
4. Kelley, MJ, Elliot LP, Shulman ST, Ayoub EM, Victorica BE, and Gessner IH: The Significance of the Left Atrial Appendage in Rheumatic Heart Disease, Circulation, in press, June 1976.
5. Segal BL, Koneck LL, Kawai N. Kotler MN, and Linhart JW: Echocardiography: Current Concepts and Clinical Application, Circulation 57:267-283, 1974.
6. Tamer, DM: Acute Rheumatic Fever in a South Florida County Hospital, 1967-1971, Circulation 50:765-767, 1974.
7. Soler, G: personal communication.

Contributors to The Journal Make an Interesting Cluster

Over the years a source of pride to numerous physicians who served on its staff has been the fact that material published in **The Journal of the Florida Medical Association,** official organ of an outstanding state association, is prepared by physician authors for physician readers. The editorial policy historically has emphasized that The Journal is their communitive medium. First priority for publication is allotted to scientific papers, special articles, editorials and comments written by Association members. The Journal's reason for being is to provide a practical means for Florida's physicians to share their experiences so that a greater benefit to patients may be derived from practice of the art and the science of medicine.

Those physicians who serve as editors and in other capacities necessary to publishing a monthly journal are proud—and justly so—of what has been accomplished.

A thumbing of issues produced in past years demonstrates the prominence of Florida authors. The scientific papers and special articles clearly reflect the sharing attitude of physicians. Surely the quality of medicine has benefited.

A tabulation of authors during 1975 shows an interesting cluster. Those in five cities produced almost two thirds of the 175 presentations. Physicians practicing in 26 cities provided all the contributions from Florida. Three presentations were contributed by out-of-state authors.

As the staff of the Florida Journal, we cannot believe that worthwhile and reportable experiences are limited to so few practice locations. Ability and experience—brain power, if you will—is not so clustered. We believe that virtually every practicing physician has something worthwhile and important to pass on to his fellow practitioners about things medical in this state.

It may not be the scholarly presentation of a new and different regimen or procedure. It may not be the report of a significant number of successful cases which are being eagerly awaited by eminent authorities proving that their theory was indeed the correct one.

The paper could be the simple explanation of how one physician worked out an office routine with his nurses which reduced the patients' waiting time. It may be the report of a better way to handle the weekend gardener with light eruption on his hands and face who is having trouble accepting the simple solution to his problem—a straw hat to shade his face and gloves to protect his hands.

The editors are aware of the socioeconomic complexities of present-day medical practice. There is need for full and frank discussion of the various problems, and The Journal could be that forum. It could be the medium by which Association members speak to their Board of Governors thereby offering direction to the policy-making House of Delegates. Some problems are unique to certain areas and these should be placed before the entire Association membership.

The editors are aware, too, that this is a time of division and upheaval, questioning and seeking. It has not been determined, yet, that this is all bad or good. But, members of the Association should be recording their thoughts and opinions in their Journal for in the consensus there may be a clear direction. They should have a sense of history, appreciation of tradition, heritage, and the written word. After all, it has been the one that endured.

E. Charlton Prather, M.D.
Associate Editor



This map shows distribution of authors contributing material to the Journal in 1975. The stars denote the city. The circled numbers indicate the number of papers contributed from that city.



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6869 FIFTH AVENUE SOUTH
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Others Are Saying

If you Become a Computer Kickout

By Rose E. London, M.D., FACP
with helpful assistance of Drs. Milton E. Lesser, Charles F. Tate, Robert E. Bauer and Charles P. Hayes

In the event that you receive a letter selecting you for peer medical utilization review, a statement will be made as to the reason computer analysis has selected you. Length of stay in hospital per diagnosis, unusual cost per office visit, unusual frequency of visits, unusual cost per year, number of nursing home visits, etc., may be the factor that sets your practice outside the average or norm. It is important for you at this point to analyze in what way your practice might be at variance with other physicians in order to understand what your reviewers are looking for. And you should review the list of patients selected with this in mind. If, for example, you have volunteered to take cases from your hospital emergency room, this may account for the unusual severity of illness, complicated nature and prolonged course of the majority of your in-patients. You may be covering a nursing home which would account for an unusual percentage of nursing home visits. If you are a hematologist or oncologist, you may require certain laboratory work on each and every visit in order to provide appropriate supervision of medication.

INPATIENT REVIEWS: You will notice that among the cases selected that there will be short, medium and long stay cases. It is well to obtain all of these from your hospital record room as soon as possible and review them in the following manner. For each chart, make up a summary sheet which will include: 1. Reason for hospitalization; 2. Additional pre-existent diseases or problems likely to cause longer hospitalization than would be predicted on the admitting diagnosis alone; 3. Unusual features of socioeconomic nature affecting the patient and age factors which conceivably would necessitate arrangement for extended care facilities such as living alone, poverty level, senility, etc.; 4. Assemble from the chart chronologic complicating findings or new illnesses as they appeared on successive days of hospitalization. Note the dates of consultations and their effect on indicating further workup. Note date of surgery and number of days prolonged for this reason; 5. In general, state your opinion as to why this particular case merited longer hospitalization than you ordinarily might have anticipated. Also indicate whether additional hospitalization, problems or death appeared subsequent to the patient's discharge as an indication of the unusual seriousness of the patient's illness. Your office notes may be of value in supporting your contention that this was a more serious disease of unusual complexity.

Documentation of all these factors is important and if you have not already dictated a summary for your medical supervision of a primarily surgical problem, you should do so and add to the existing chart. If your consultants have not fully expressed themselves on your chart, a further summary from these individuals even if done after discharge may assist your documentation.

OFFICE CASES: Should be handled in a similar fashion. Make a sequential summary of the reason for each visit and the appropriateness of laboratory tests on each visit. The unusual cost of individual visits may actually reflect the fact that you have seen your patient only once or twice a year for a complicated illness and are able to care for him adequately without unnecessary multiple visits. Your documentation of telephone calls listed in your chart will verify this fact. More frequent visits may indicate a more critically ill patient who requires supervision at weekly or bi-weekly intervals and it is well to point out the spacing of visits as occurring not on routine fashion but rather in relationship to various illness or medical problems with long intervals between when the patient is doing well. The overall mortality again is of importance in evaluating each patient as an index of the more critical nature of his medical problems. Whatever socioeconomic or age factors you have accumulated on each patient will be of value in explaining the necessity of more frequent visits than you ordinarily might need in similar cases.

The Day of Peer Review

Bring all the charts with you and avoid rushing. Do not allow yourself to become rattled, belligerent or overly anxious. Be pleasant and open in your dealings with fellow physicians who have no reason to persecute you. They are attempting to understand why you do not fit into the profile of the average physician. Try to explain to them this difference as a result of your own analysis of your practice. When you are asked questions about selected cases, try to elaborate on your chronological summary that you

have already prepared. Being well prepared is a great asset.

How to Avoid Peer Review

A. The Art of Self-Defense in Keeping Records:

1. State reason of a) hospitalization; b) each office visit.

2. If possible, dictate an admitting history which will be valuable to you and to concurrent physicians in management of the patient. This same type of note on new office patients is very valuable for potential hospital admission or correspondence with other physicians or insurance companies. It is also a reminder to you as you glance through the chart on every re-visit of your patient.

3. Write a note to document each visit. This need not be long, but should review new complications, progression or regression of disease, new laboratory observations, major decisions as to further workup, consultations, treatment or surgery. Do not say 'status quo' or 'no change'. Your notes are your most important method of explaining your activity to yourself or to a concurrent physician and will help you in writing your summary.

4. Dictate a clear summary of all problems encountered, solutions, essential laboratory work and discharge medication. Be sure to list all complications with dates, as well as final diagnosis and concurrent diseases. Even if the case becomes a surgical case with a surgeon writing a summary, write your own summary of medical problems and the reason for concurrent care.

5. Telephone conversations should be recorded on the office chart whenever possible indicating symptoms, medications and orders to the patient as well as discussions with consultants. This will not waste your time on the telephone, and will be very valuable in the overall care of the patient.

6. Periodically a dictated note on each patient summarizing the general evolution of diseases, trends, new diseases, medication changes, etc. is of great value. Some physicians also like to keep a list of important diagnosis on the inside of the patient's folder for quick reference.

B. Specific recommendations of the Dade County Medical Utilization Review Committee:

Hospital

1. The need for concomitant care should be established at the onset of treatment. Better communication must be established between surgeon and medical man as well as between attending physician and consultant regarding primary care responsibility including frequency of visits and writing of orders. The PMUR committee has held that an internist should not bill a patient for daily visits when the patient has a surgical procedure unless the patient's coexisting medical problem warrants daily exams by the internist. A patient with stabilized coronary disease, in other words, should not require daily exams from his internist if he is in for a herniorrhaphy. The concepts of, "I'm the captain of the ship" or "he's my patient after all" shouldn't pertain to the need for daily bills.

2. Itemized fees for surgeons should be disallowed on the basis of pre- and post-operative visits, except for a pre-operative consultation or unusual complications post-operatively which require treatment by the surgeon.

Office

1. When laboratory tests are performed for screening purposes they should be billed on a fee schedule customarily used for screening profiles instead of on an individual basis. The PMUR committee frowns upon the high cost of multiple tests done manually as a screening device, but understands the importance of the accuracy and emergency use of manual tests as done in physicians office for the immediate treatment of patients.

2. Compensation should not be allowed for multiple injections of medications not specifically indicated for the illnesses treated. The PMUR committee ordinarily does not understand the frequent use of injectable iron vs. oral, injectable antibiotics when there is no follow-up with oral antibiotics, injectable ACTH as treatment of choice for osteoarthritis, or even injectable diuretics in some of the circumstances reviewed.

3. Unusual frequency of visits is self explanatory. Ancillary procedures usually include EKGs, x-rays and laboratory tests. Sometimes they include fluoroscopy, physiotherapy and itemized injectable medications. The computer print-outs of unusual cost per visit or unusual cost per patient per year mean that the number of ancillary procedures is unusually high or that the cost of these tests is unusual. Therefore, there should be documentation as to the need for frequent use of office ancillary services.

▶ Dr. London, 1688 Meridian Avenue, Miami Beach 33139.

Reprinted from The Florida Internist, Vol. 10, No. 1, January, 1976.



Just what is Florida Drug Utilization Review all about?

Drug Utilization Review is part of the Medicaid drug program in your state. The goal is to assist in the delivery of rational drug therapy for Medicaid patients and reduce the over all cost of the Medicaid drug program.

ow can Drug Utilization Review do that?
is done by reviewing Medicaid drug use and sharing the sults of the review with those doctors and pharmacists volved in treating the patient. When a Medicaid prescripon claim is processed, a computer records who received e drug, who prescribed it, who dispensed it, and what nd of drug it was. Once a month, the computer compares e drug use records of each patient with several criteria, ch as kinds of drugs used, amounts purchased, number doctors visited, and so on.

When a patient's drug use goes beyond any of the iteria, the computer prints a report for review by the rug Utilization Review Committee.

st who is the Drug Utilization Review committee?
is a group of fellow health care professionals—physicians nd pharmacists from your area. Committee members are lected from nominations made by your local medical and harmaceutical associations. Each member serves for 1 to 3 ars. You may be invited to serve on the committee at some ne.

hat does the Drug Utilization Review committee do?
ne committee reviews patient drug histories showing ug use patterns which exceed criteria set for the program. the questionable pattern appears to be minor or tempory, the committee may decide to take no further action.

If the situation is more serious, the committee will write the doctors and pharmacists involved to advise them of e potential problem. For example, the records might ow that a patient is going to several doctors to get escriptions for the same drug. The committee would vise each of the doctors of this practice. In another case, e committee might recommend that a doctor prescribe aintenance drugs in larger, more economical quantities, he patient's condition warrants it.

Are you trying to tell me how to treat my patients?
Not at all. Your patients' treatment is in your hands, where it belongs. All Drug Utilization Review does is give you information about your patients' drug use that hasn't been available before. The committee can't dictate the kind of drug therapy you use, and wouldn't want to if it could.

What do I have to do if I get a letter about a patient?
The committee will ask you to review your records to see if the situation described in their letter is with your knowledge and conforms with your diagnosis and treatment. If so, please advise the committee of your diagnosis and treatment plan so they'll know that the drug use is appropriate and won't send additional letters in the future.

If the situation is not called for by your treatment plan, the committee asks that you review the situation and make those changes you feel are necessary. In all cases, they try to make it as easy as possible for you to respond to the committee and use the information provided.

How can a physician find out more about the Drug Utilization Program?
A pamphlet which explains the Drug Utilization Review program in detail is available or a visit to your office by a staff member can be arranged upon request. A speaker or a color/sound film can also be provided for local medical societies or other groups interested in further information about the program. Your peers who are members of local peer review committees will be glad to explain the program personally or answer any questions. If you will write or call PAID Prescriptions, any information requested will be provided including the names of committee members in your local area.

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Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Current Medical Diagnosis & Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1,028 Pages. Soft Cover. Price $14.00. Lange Medical Publications, Los Altos, California, 1976.

This book is a competitive text for the hard cover Saunders text book, Current Diagnosis by H. Conn, M.D., which costs twice as much. It has an excellent quotation from Sir Robert Hutchinson, "From inability to let well alone; from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, Science before Art and cleverness before common sense; from treating patients as cases, from making the cure of the disease more grievous than the endurance of the same, Good Lord deliver us."

The editors of this book both have research appointments and are well equipped to evaluate current diagnosis and treatment. It is written by 32 authors and has 33 chapters. I was especially interested in the proportional number of pages given to various subjects in the book. For example, in this book of 1,028 pages, 42 pages are devoted to the skin and its appendages by Rees B. Rees who is the Professor of Dermatology at School of Medicine, University of California, San Francisco.

Because of a recent case in my practice, my attention was attracted on page 323 to the subject of fecal impaction for which the treatment is well recognized but the diagnosis is often overlooked. There is a section on diseases of the breast and an interesting diagram of the percentage of location of the cancers of the breast, on a clockwise basis. They mention that the mammogram is often positive before lesions are palpable.

There is a good detailed section on the tranquilizers. The number of these tranquilizers are so extensive that I feel it is best to get accustomed to using a very few and knowing them well rather than trying to evaluate the effectiveness of all of them.

An interesting quote on page 641 is by Thomas Browne who said, "The long habit of living indisposeth us for dying."

Nutrition receives excellent coverage. There is a considerable amount of information in the sections on infectious diseases. There is also an excellent chapter on anti-infective chemotherapeutic and antibiotic agents. There is a chapter on poisons which appears to be all inclusive. This latter comment holds for the book as a whole and in many ways is of an encyclopedic nature in its field. An appendix contains substantial additional information. It is highly recommended.

Harry C. Goldberg, M.D.
Palm Beach

Dr. Goldberg is a practicing Dermatologist In Palm Beach.

Hypnosis in the Relief of Pain by Dr. Ernest R Hilgard and Dr. Josephine R. Hilgard. 262 Pages Price $12.50. William Kaufman, Inc., Los Altos California, 1975.

I found this book to be well written with an excellent predicate based on the history of hypnosis The experimentation is well documented throughou the text along with copious references, etc.

The correlation between hypnosis and anesthesi for thoracic and other major surgery with the new Chinese methods of acupuncture was also well presented.

The horizon of hypnosis for the control of pain was certainly broadened in this text.

Jacob Green, M.D
Jacksonville

Dr. Green is a practicing Neurologist in Jacksonville.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Physician's Handbook by Marcus A. Krupp, M.D.; Norman J. Sweet, M.D.; Ernest Jawetz, M.D.; Edward G. Biglieri, M.D. and Robert L. Roe, M.D. 18th Ed. 754 Pages. Price $8.00. Lange Medical Publications, Los Altos, Calif., 1976.

Emergency Medical Care edited by Clifford Findeiss, M.D. 333 Pages. Illustrated. Price $17.95. Stratton Intercontinental Medical Book Corporation, New York, 1974.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

Principles of Clinical Electrocardiography, 9th Edition by Mervin J. Goldman, M.D. 412 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1976.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

The New Way to Live With Diabetes by Brian Boylan and Charles Weller, M.D. 140 Pages. Price $2.50 (paperback). Doubleday & Company, Inc., New York, 1976.

Foreign Travel Immunization Guide by H. H. Neumann, M.D. 32 Pages. Price $2.50. To order: Send check to Box 611, New Haven, Connecticut 06503.

The Woman Alcoholic by Vera Lindbeck. 28 Pages. Price 35¢. New York, Public Affairs Pamphlets, 1975.

Focus on Care of the Elderly by Donald F. Phillips et al. 114 Pages. Price $4.75. Contemporary Publishing, Inc. Wakefield, Massachusetts, 1975.

Preparation for Parenthood Through Group Discussion by Aline B. Auerbach. 57 pages. Available on request from Educational Services, Patient Care Division, Johnson & Johnson, New Brunswick, N. J. 08903.

This book by a parent group consultant is subtitled, "A Guide For Nurse-Leader of Expectant-Parent Classes". This guide includes chapters on organization of expectant parent discussion groups, basic requirements for leadership, as well as techniques of group discussion and suggested curriculum. It includes a bibliography for suggested reading.

Blood: The River of Life by Donald R. Avoy, M.D. 76 pages. Price .75. Available from: American Red Cross Blood Program, National Headquarters, Washington, D.C. 20006.

This small book, complete with glossary should prove useful to laboratory technicians, nursing and allied medical personnel. This booklet includes function of the blood components as well as blood diseases. A brief section covers the Red Cross blood program.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus,** volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publications should be designated "For Publication."

NORTH FLORIDA REGIONAL HOSPITAL

and

THE NORTH FLORIDA REGIONAL MEDICAL FOUNDATION

Announce

"THE THIRD ANNUAL CARDIOVASCULAR SYMPOSIUM"

SEPTEMBER 9-10, 1976

THE GAINESVILLE HILTON INN — GAINESVILLE, FLORIDA

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

This symposium is designed to review and explore the diagnostic procedures and therapeutic modalities that are available for the detection and treatment of cardiovascular disease. A special evening session is devoted to the use and value of echocardiography. An outstanding faculty has been assembled for the symposium and the program should be of interest to all physicians taking care of patients with cardiac disease.

FACULTY

CHRISTIAN BARNARD, M.D.	MICHAEL DeBAKEY, M.D.	RENE FAVALORO, M.D.
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RICHARD L. POPP, M.D.	MICHAEL JOHNSON, M.D.	JOHN H. LARAGH, M.D.
THOMAS B. FERGUSON, M.D.	JOSEPH W. LINHART, M.D.	SPENCER B. KING, III, M.D.

(Approval for credit for CE units has been requested from the AAFP, FMA, AACN and FNA.)

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Hotel, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton Inn direct, (904) 377-4000.

RESERVATION FEES: $150. — all physicians
50. — paramedical personnel (nurses, technicians, etc.)

MAKE CHECKS PAYABLE TO: THIRD ANNUAL CARDIOVASCULAR SYMPOSIUM

MAIL TO: Howard W. Ramsey, M.D.
Program Director
North Florida Regional Hospital
P.O. Box 13494
Gainesville, Florida 32604

REGISTRATION IS LIMITED — REGISTER EARLY

(Fees will be refunded for cancellations received no later than August 27th.) For further information write to: Howard W. Ramsey, M.D., at the above address.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

JULY

1976 Clinical Conference on Pre-Hospital Emergency Care, July 9-11, Orlando Hyatt House, Orlando. For information: Registrar, 1976 Clinical Conference on Pre-Hospital Emergency Care, 1919 Beachway Rd., Suite 5-C, Jacksonville 32207.

AUGUST

1976 Postgraduate Obstetric Pediatric Seminar, Aug. 10-12, Konover Hotel, Miami Beach. For information: Jorge Deju, M.D., Box 210, Jacksonville 32201

SEPTEMBER

Clinical Electrophysiology, Sept. 15-17, Wolfson Auditorium, Mount Sinai Hospital, Miami Beach. For information: CME Coordinator, Mount Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

Twenty Fourth Annual Diabetes Seminar, Sept. 17-19, Jacksonville. For information: Robert Miller, M.D., 1545 San Marco Blvd., Jacksonville 32207.

OCTOBER

First Annual Reunion, University of Miami, Department of Family Medicine, Oct. 3-5, Americana Hotel, Miami Beach*

Obstetric/Gynecology Review Course, Oct. 3-10, Miami*

Topics in Family Medicine 1976, Oct. 6-10, University of Miami School of Medicine, Department of Family Medicine*

Review Course on **"Fundamental and Clinical Aspects of Internal Medicine,** Oct. 10-23, Key Biscayne Hotel, Miami*

17th Workshop in Electrocardiography for Cardiac Nurses & Interested Physicians, Oct. 14-18, Tides Hotel, Redington Beach, St. Petersburg. For Information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

25th Basic Colposcopy Course, Oct. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Charles B. Slack, Inc., 6900 Grove Rd., Thorofare, N.J. 08086

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel, Key Biscayne.*

FSIM/ACP Joint Fall Meeting 1976, Oct. 22-24, Marco Beach Hotel and Villas, Marco Island. For information: Florida Society of Internal Medicine, 515 Lomax St., Jacksonville 32204

NOVEMBER

Program for Foreign Medical Graduates, Nov. 1 & Jan. 22, Miami*

Hepatobiliary Disease in Clinical Practice, Nov. 11-13, Miami*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 11-13, Miami*

Legal and Medical Aspects of Human Sexuality, Nov. 18-20, Miami*

Anesthesia Management for the Surgical Patient, Nov. 29-Dec. 12, Miami*

Emergencies in Internal Medicine, Nov. 30-Dec. 4, Miami*

1977

JANUARY

Pediatric Nephrology Seminar IV, Jan. 3-6, Miami*

Neuro-Ophthalmology Seminar, Jan. 3-7, Miami*

Midwinter Cruise—Symposium on Intensive Care, Jan. 6-15, Miami*

Miami Winter Symposia—Biochemistry, Jan. 10-14, Miami*

Human Disease Related to Food and Chemical Sensitivity, Jan. 12-15, Miami*

11th Annual Postgraduate Seminar in Surgery, Jan. 12-15, Miami*

Hematology and Oncology 1977, Jan. 13-16, Miami*

Nephrology 1977, Jan. 14-15, Miami*

Pulmonary Disease 1977, Jan. 14-15, Miami*

Arthritis 1977, Jan. 14-16, Miami*

Gastroenterology and Hepatology 1977, Jan. 14-16, Miami*

Internal Medicine 1977, Jan. 15-21, Miami*

Second Review and Practical Advances in Pathology, Jan. 16-21, Miami*

9th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-22, Carillon Hotel, Miami Beach. For information: Charles Lynne, M.D., 1200 N.W. 10th Avenue, Miami 33136

Infectious Disease—Immunology 1977, Jan. 22-23, Miami*

Endocrinology 1977, Jan. 22-23, Miami*

Basic Sciences for the Practicing Physician: Biochemistry, Jan. 22-23, Miami*

Cardiology 1977, Jan. 24-26, Miami*

4th Annual Postgraduate Course in Practical Modern Neurology, Jan. 24-27, Miami*

Florida Midwinter Seminar on Ophthalmology, Jan. 30-Feb. 2, Miami*

FEBRUARY

Florida Midwinter Seminar on Otolaryngology, Feb. 3-5, Miami*

3rd Annual Vail Conference in Anesthesiology, Feb. 5-12, Miami*

Symposium on Stroke—Moderns Trends in Cerebrovascular Disease, Feb. 9-12, Diplomat Hotel, Hollywood. For information: Mr. Ronald A. Nelson, Executor Director, Heart Association of Broward County, 440 N. Andrews Ave., Fort Lauderdale 33301

Winter Management (Anesthesiology), Feb. 12-19, Miami*

Basic Neurology for Psychiatrists, Feb. 28-Mar. 4, Miami*

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE
THIRD ANNUAL REVIEW COURSE
"Fundamental and Clinical Aspects of Internal Medicine"

KEY BISCAYNE HOTEL OCTOBER 10-23, 1976 **KEY BISCAYNE, (MIAMI) FLORIDA**

Directors: William J. Harrington, M.D., Eric Reiss, M.D., and Neal S. Bricker, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for internists who are preparing for certifying examinations. It is intended to provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Each subspecialty will be reviewed as described under "Schedule." Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed texts and references will be provided to all registrants, and audio-visual teaching aids will be available for self-instruction and reinforcement.

SCHEDULE

WEEK I—October 11-16, 1976

October	11	Pulmonary Diseases
"	12	Nephrology
"	13	Hypertension & Acid Base Disorders
"	14	Infectious Diseases & Immunology
"	15	Hematology
"	16	Oncology & Genetics

WEEK II—October 18-23, 1976

October	18	Rheumatology
"	19	Cardiology
"	20	Neurology & Psychiatry
"	21	Endocrinology & Metabolism
"	22	Clinical Pharmacology, Dermatology Toxicology & Environmental Medicine
"	23	Gastroenterology & Hepatology

LECTURES
The course will consist of daily sessions, Monday through Saturday for two successive weeks. On each day beginning at 8:00 a.m., fundamental and core material on a given topic will be presented. After a coffee break (10.00-10:30 a.m.), recent advances will be reviewed from 10:30 a.m. to 12:30 p.m. and from 5:00 to 7:00 p.m.

LEARNING CENTER
Fully automatic synchronized cassette/slide sound projection of lectures.

MEET THE FACULTY SESSIONS
Will be held every day from 3:00 to 4:30 p.m. and will consist of simultaneous small group conferences in which illustrated aspects of each subspecialty will be presented, followed by open discussions and topics not formally reviewed in the lectures.

SELF-TEACHING AUDIOVISUAL AIDS
Television sets with tape players and slide review projectors with cassette tapes will be available throughout the entire meeting.

This course is accredited on an hour by hour basis (90 hours-Category I) toward the AMA's Physician's Recognition Award and the Florida Medical Association, Category A.

REGISTRATION FEES:

Entire Course (Oct. 11-23)	$500
Week I (Oct. 11-16)	$300
Week II (Oct. 18-23)	$300
Per day (minimum of 3 days)	$ 70

Checks payable to: U/MIAMI INTERNAL MEDICINE REVIEW COURSE

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For information and application write to:

J. BOCLES, M.D.
Department of Medicine
University of Miami School of Medicine
P.O. Box 520875, Biscayne Annex
Miami, Florida 33152
Phone: 305/547-6063





Col. Ray A. Olsson, MC, USA . . . has been appointed to the Ed C. Wright Chair of Cardiovascular Research at the University of South Florida College of Medicine, effective July 1.

Prior to reporting to Tampa, Dr. Olsson will retire from the Army. His most recent service assignment has been Director of the Division of Medicine and Chief of Cardiorespiratory Disease at Walter Reed Army Institute of Research.

"We are particularly confident that (Dr. Olsson) will attract high calibre medical students and trainees to his research program," according to Roy Behnke, M.D., Chairman of the Department of Medicine at USF.

A native of California, Dr. Olsson, 45, received his M.D. degree from the George Washington School of Medicine in 1956. He is a Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians.

The Wright Chair is named in honor of a St. Petersburg businessman whose bequest to the Suncoast Heart Association made the professorship possible.

Seven Florida physicians . . . are among 314 doctors who were elected in April to Fellowship in the American College of Physicians.

They are: Lawrence M. Fishman, M.D., Ruth J. Ratzan, M.D., and Franz H. Stewart Jr., M.D., all of Miami; Kenneth R. Ratzan, M.D., Coral Gables; George A. Anderson, M.D., Jacksonville; Kevin J. McCarthy, M.D., Lake Worth, and Peter O. Knight, M.D., of Tampa.

James J. Cerda, M.D. . . . has been honored for teaching excellence by graduating medical students at the University of Florida.

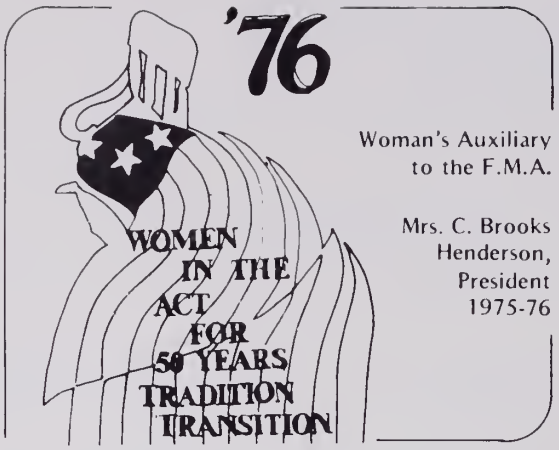
Dr. Cerda was presented with the 1976 Hippocratic Award for Teaching Excellence during ceremonies on the lawn of the Shands Teaching Hospital on May 7. The award is given to the clinician teacher whom the medical students believe "best exemplifies the ideals of Hippocrates, the Father of Medicine."

A native of Brooklyn, N.Y., Dr. Cerda has been a member of the faculty since 1972. He is Associate Professor of Medicine and Associate Chairman of the Department.

Dr. Cerda, a gastroenterologist, also is Director of the J. Hillis Miller Health Center's Nutrition Laboratory.



James J. Cerda, M.D. (left) chats with student leader Duncan Marsh beneath the "Tree of Hippocrates" after receiving the 1976 Hippocratic Award for Teaching Excellence at the University of Florida College of Medicine.



Auxiliary President's Report for Year 1975-76

Mrs. C. Brooks Henderson

My theme for the Auxiliary this year was "Women in the Act for 50 Years—Tradition—Transition." This was the year we celebrated the Golden Anniversary of WA/FMA and the Bicentennial of our country. In this memorable year, our National Auxiliary has undergone the largest transition in its history. Previously, Auxiliary programs and projects were introduced by suggestion of the National office; today we realize more than ever the importance of each county with its own peculiar needs. This year, for the first time, we encouraged each county in the state to make a survey to identify local needs. One-way communication from national to state and county has been replaced by two-way dialog. A Project Bank has been created; this is a whole new concept. County auxiliaries were encouraged to use the Project Bank to share information about community service projects and programs. All this is part of a move to streamline Auxiliary operations for economy and service.

We are proud of a number of achievements this year. One county Auxiliary, which had disbanded, has reorganized. Another county added a branch Auxiliary. Another county medical society has requested information to organize an Auxiliary.

Our Auxiliary was invited to meet with State of Florida Department of Education concerning introduction of Health Careers Education in the Florida School System.

At our Fall Conference over $3,050.92 was realized from our International Health Bazaar. This is over $1,000 more than any previous year. This money will be used to sponsor three SKIP (Scholarship for Kids of Indian Physicians) children and support Project Concern and M.A.P. (Medical Assistance Program).

To date, over $59,959 has been raised for AMA-ERF. The 1975 grant distribution of AMA-ERF funds to Florida medical schools made in March, 1976 were:

UNIVERSITY OF MIAMI	$ 6,084.67
UNIVERSITY OF FLORIDA	9,937.24
UNIVERSITY OF S. FLORIDA	9,243.84
FLORIDA STATE UNIVERSITY	2,943.89
Total	$28,209.64

This year Florida Medical Foundation realized over $4,037.51.

National High Blood Pressure Month was in May. Last year we were an endorsing organization. This year we were invited to be a sponsor as was A.M.A.; with your approval we accepted. This meant greater participation on local and state levels. It's good public relations for organized medicine.

At the national level, three meetings were streamlined into one. This was the 1975 Leader-

Mrs. Henderson is immediate past president of WA/FMA.

ship Confluence held in Chicago last October. I am proud to announce that 10 county presidents-elect, our state President-Elect, Mrs. William H. Harrison, and myself, represented Florida. This was the total delegation invited to attend.

For the first time our state Auxiliary was one of the co-sponsors of the Quality of Life Conference.

Another first was our invitation to attend the Council on Legislation of the FMA.

Dr. Astler specifically urged that the Auxiliary give priority to Legislation and Public Relations. In June, letters were sent to all county presidents and chairmen of these committees implementing his ideas.

In August, at the request of the President of the National Auxiliary, we began participation in the state Implementation Committee for Immunization Action Month. The last week in April a representative from our Auxiliary attended a meeting to plan for the influenza vaccination campaign this fall.

We used our fall conference to educate new county officers. Subjects covered included: FMA position on legislation, public relations and how the Auxiliary can help; Health Education—The Project Bank—and the 50 Year History of WA/FMA. Featured speakers included FMA President, Vernon B. Astler, Lt. Gov. Jim Williams and others. Honored guests included Senator and Mrs. Buddy MacKay and Mayor and Mrs. Jim Kirk of Ocala.

Mrs. James J. DeVito has compiled the History of WA/FMA. We are indeed grateful to her.

Twenty-eight county medical societies have organized auxiliaries with a total membership of 4,291, which is an increase of 184. Did you know that Florida is the sixth largest Auxiliary in the 50 states?

This year we have increased FLAMPAC membership. FLAMPAC has helped to influence legislation and encourage local auxiliaries to be more active for the betterment of health in their communities. We would like to encourage the county auxiliaries to meet the needs of their communities and stress public relations in programs and projects as they participate. Our programs are supportive of the aims of Florida medicine.

This year there was a new format for the Day in the Legislature. We first met in Tallahassee for a workshop. Panelists were staff from the FMA Legislative office. After the Workshop we took our legislators to dinner. Next morning we had an opportunity to see the Legislature in action. The climax to the meeting was a luncheon addressed by Lt. Gov. Jim Williams.

At the local level county projects included:

WORRY CLINICS
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RAISING MONEY FOR AMA-ERF
DRUG FUND FOR INDIGENTS
MEALS ON WHEELS
HELP WITH LANDSCAPE OF HOSPITAL
HELP TO MIGRANT WORKERS
DIRECT RELIEF—PSYCHIATRIC PATIENTS
COURT AID PROGRAM
ANTI-SMOKING PROGRAM
TRAVELING HEALTH FAIR
MAINTAINING MEDICAL HEALTH EXHIBIT IN CHILDREN'S MUSEUM
HEARING TESTING PROGRAM
APPRECIATION COFFEE FOR HOSPITAL VOLUNTEERS
NUTRITION PROGRAM BY COUNTY HEALTH DEPARTMENT
HEALTH SCIENCE EXHIBIT
LEARNING SERVICE PROGRAM
2 AUXILIARY MEMBERS SERVE ON HIGH BLOOD PRESSURE COUNCIL
PARENTS ANONYMOUS
HEALTH FAIRS
HEALTH AWARENESS WORKSHOP
SUPPORTING BLOOD BANK
EMPHASIZING BLOOD DONOR MONTH
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BICYCLE SAFETY PROGRAM

I have tried very hard to lay the ground work for this transition with the help of national, state and local officers. I think Florida is ready to move forward.

If you need us in specific areas, please encourage your county medical society to seek help and cooperation from its county Auxiliary members—if you ever need your spouse, I should think it is now!

Let us know how we can help you.

This indeed has been a challenging, rewarding and a great year. It has been a privilege and honor to represent each of your wives.

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ACCREDITED BY THE J. C. A. H.

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physicians wanted

FAMILY PRACTITIONERS

MIAMI, FLORIDA: G.P. — Seven man multi-specialty, fee-for-service group is seeking a G.P. to join the group. Contact S. L. Weiss, M.D. or Eli Galltz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

FAMILY PRACTITIONER: Will consider association or partnership. Ample facilities. Charles W. Bush, M.D., 4337 Seagrape Drive, Lauderdale-by-the-Sea, Florida 33308. Phone (305) 776-1155.

GENERAL PRACTITIONER WANTED. Central Florida area, near Disney. New patients available from retiring physicians. Local hospital willing to help get started. Emergency room work available for both remuneration and new patients. Rapid growth community. All specialties available. Prefer American graduate. A minimum guarantee or salary can be worked out for the right individual for this unique opportunity. Please write: Hospital Administrator, P.O. Box 1626, Kissimmee, Florida 32741.

GENERAL PRACTICE: Opening for fourth man in modern office building located near two well equipped hospitals. Salary first year; partnership later. Well established practice in a beautiful town with hills, lakes and oranges. Contact Drs. B. F. Brokaw or J. W. Elmer, 802 E. Dixie Ave., Leesburg, Florida 32748. Phone: (904) 787-1324.

FAMILY PRACTITIONER OR INTERNIST to take over growing general practice. Perfect location opposite progressive general hospital in the best of Central Florida. Write C-741, P.O. Box 2411, Jacksonville, Florida 32203.

EXCELLENT OPPORTUNITY IN TAMPA, FLORIDA FOR FAMILY PRACTICE AND INTERNAL MEDICINE to join group practice close to major hospital and medical center. Physicians income based on percentage of billings with guarantee and opportunity to participate in ownership of center. No investment required. For full details contact W. R. Wallace, Business Manager, Oaktree Medical Center, 1113 East Buffalo Avenue, Tampa, Florida 33633. Phone: (813) 247-5921 or 855-4064.

SPECIALISTS

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

GASTROENTEROLOGIST NEEDED by multispecialty 20-man group in Aventura, North Miami Beach, $30,000 plus percentage. Also needed is a part time neurologist, a neurosurgeon and a vascular/thoracic surgeon. This is a quality, fee-for-service group in private practice and it is not an HMO or Medicare clinic. Aventura Medical Center, 2956 Aventura Boulevard, North Miami Beach, Florida 33180.

MIAMI, FLORIDA AREA: Multispecialty group fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

ORTHOPAEDIC SURGEON — FLORIDA PRACTICE. Board qualified or certified to join 2-man highly reputable orthopaedic practice in beautiful community. Send professional and personal critique to L. Cerino, M.D., 1800 North Federal Highway, Pompano Beach, Florida 33062. Phone: (305) 943-1922.

ANESTHESIOLOGIST WANTED: Free standing, outpatient surgical facility, Dade County, Miami, Florida. Elective day time schedule, off weekends and holidays, no calls. Contact: Executive Director (305) 595-9511.

IMMEDIATE OPENINGS FOR RADIOLOGIST, OTOLARYNGOLOGIST. Liberal financial assistance, attractive guaranteed income. Must be Florida licensed. Contact Claude L. Weeks, Administrator, Flagler Hospital, P.O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

TWO ANESTHESIOLOGISTS NEEDED: Growing multispecialty group seeks affiliation with board certified or eligible anesthesiologists. Excellent opportunity to either join group or provide service to its staff and other physicians in the community. Beautiful northeast Florida coastal city with excellent hospitals and good school system. Write C-698, P.O. Box 2411, Jacksonville, Florida 32203.

OPENING FOR DERMATOLOGIST, in office with five established internists. Board certified or eligible. Take over established practice. Arrangements open. Reply to C-743, P.O. Box 2411, Jacksonville, Florida 32203.

IMMEDIATE OPENING FOR RADIOLOGIST. Liberal financial assistance, attractive guaranteed income. Must be Florida licensed or eligible. Contact Claude L. Weeks, Administrator, Flagler Hospital, P. O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

WANTED: Recently trained, Board certified Internist to replace eighth man in an internal medicine group P.A. Excellent practice on the Gold Coast. Guaranteed $35,000 plus percentage. Full partnership in two years. Everything furnished except house and automobile. Good retirement plan. Reply: Box 4450, Fort Lauderdale, Florida.

MISCELLANEOUS

ADDITIONAL PHYSICIANS URGENTLY NEEDED in rapidly growing Gulf Coast area. Most needed are internists, ENT's and pediatricians. Excellent private practice opportunity. Rural. Drawing area 40,000. 200-bed excellently equipped hospital. Excellent schools. One and one half hours from medical schools and metropolitan areas. Office space available. Send curriculum vitae to C-708, P.O. Box 2411, Jacksonville, Florida 32203.

LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact: Jake Truslow Company, P.O. Box E-S, Venice, Florida 33595. Phone (813) 485-4617.

PSYCHIATRIST/G. P. PHYSICIAN — Openings are anticipated from time to time in well established Community Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse, Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume', should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital, 150 beds. Forty hour week. Benefits include three weeks vacation and two paid medical conferences. Starting salary $40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: Jack Geeslin, M.D., Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-3128.

SEEKING PHYSICIANS to relocate Marianna, Florida, trade area of 40,000 people. Recent professionals study indicated the immediate need for 7 physicians to supplement the 6 already here. Financial and business assistance available to qualified physicians. Contact Elwin O'Steen. Phone: (904) 482-4011.

CAREER ERP POSITION AVAILABLE with established group in large metropolitan medical center in Northeast Florida. Full specialty backup. Florida license required. Liberal salary with desirable fringes. Write C-714, P.O. Box 2411, Jacksonville, Florida 32203.

IS YOUR COLLECTION RATE LESS THAN 85%? Does your office personnel alienate your patients when asking for payment of professional fees? Increase the efficiency of your office—collect more of the money you have earned—easily. Efficiency Enterprises, P. O. Box 1625, Ft. Myers, Florida 33902. Attn: Ms. E. Knox.

Situations Wanted

YOUNG BOARD CERTIFIED ENDOCRINOLOGIST, experienced, university trained, AOA. Desires full-time endocrinology position in Florida. Would consider DME or hospital based position for consultations and teaching. Bilingual Spanish and English. Write C-739, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD ELIGIBLE PEDIATRICIAN, university trained, licensed in Florida. Prefer hospital or clinic based position. Write C-734, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN: age 38, Board Eligible, seeks salaried position in private clinic, hospital or HMO group. Prefer Dade County area, but Collier, Broward, or Palm Beach counties also acceptable. Available September 1, 1976. Write C-733, P.O. Box 2411, Jacksonville, Florida 32203.

ALLERGIST: 40 years old, university trained and board certified. Desires relocation in Florida. Will send more vitae upon request. Contact: F. McCain, M.D. Phone: (919) 765-3756.

INTERNIST-GASTROENTEROLOGIST, 30, Proficient in endoscopy. Florida licensed seeks solo, associate or group practice in community of 10,000-20,000. Needs income guarantee. Contact: K. T. John, M.D., 104 S. Franklin Street, Winamac, Indiana 46996. Phone: (219) 946-6215.

BOARD SURGEON—50 years old, Florida licensed, interested in developing outstanding emergency department or surgical assisting. Coast preferred. Member ACEP. Write C-737, P.O. Box 2411, Jacksonville, Florida 32203.

OB-GYN SPECIALIST, Available July 1976, Board eligible. Resident Hahnemann Medical College and Hospital, P.A. Graduate University of Gujarat, India. Write C-738, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRIC PRACTICE WANTED: Board certified pediatrician desires to purchase or gradually take over established, busy pediatric practice in coastal community. Write with full details to: M. Nahas, M.D., 59-21 Calloway Street, Apt. 7H, Corona, N.Y. 11368 or call evenings (212) 271-0114.

PERIPHERAL VASCULAR SURGEON—35, completing one year vascular surgery fellowship; seeks group, association or hospital appointment. Ready to do general surgery also if necessary; completed part I surgery board available in July 1976. John Chacko, Vascular Surgery Division, Mount Sinai Hospital, New York, N.Y. 10029.

NEUROLOGIST, married, board-eligible, with four years experience in private practice in other states, seeking opportunities for solo practice. Will consider association with a neurological group or multispecialty groups. Florida licensed. Write C-740, P.O. Box 2411, Jacksonville, Florida 32203.

Practice Available

LARGE INTERNAL MEDICAL PRACTICE FOR SALE with office for rent and equipment for sale or lease and completely staffed. Write C-725, P.O. Box 2411, Jacksonville, Florida 32203.

PRACTICE FOR SALE: Family practice, well equipped office, Cape Canaveral area, situated on South Beach. Pleasant surroundings. Grossing $150,000. Potential for growth. Write C-730, P.O. Box 2411, Jacksonville, Florida 32203.

GROWING GENERAL MEDICAL PRACTICE FOR SALE, with beautiful and well-equipped office across the street from progressive general hospital. Write C-742, P.O. Box 2411, Jacksonville, Florida 32203.

Equipment for Sale

MEDICAL EQUIPMENT FOR SALE: X-ray—universal 300-MA; developer—PAKO; EKG unit and stand; pulmonary function unit; two examining tables and miscellaneous small equipment. Call: Sun Bank of South Orlando, (305) 425-1661, Bill Daughtry.

FOR SALE: ONE 15' BAHAMIAN SAILING DINGHY—fibreglass, teakwood fittings, sail and carrying trailer, $900; one Sajou's Encyclopedia of Medicine—a rare antique book collection; One Pelton Steam Autoclave; one Picker x-ray Unit, 300 ma, 125 pkv. 90/15 tilt table, fluoroscope, spot film device, floor to ceiling tube stand with electromagnetic locks, videx collimator, electronic bucky, 12/1 grid. Contact: Alex Trombly (813) 253-0481, 8:00 - 5:00.

FOR SALE: Radiographic equipment—250 MA-110KW Fisher generator, floor to ceiling tube stand, Dynamax 40 tube, Bucky flat table—good condition, $4,000. Call Dr. Jelaso (813) 446-6760, Clearwater.

Real Estate

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

ST. PETERSBURG: Pasadena Medical-Dental Building, 419 Pasadena Avenue South. New deluxe office building. Just minutes from Palms of Pasadena and St. Petersburg General Hospitals. Custom designed for your needs. For complete information call Gerald F. Dalrymple (813) 866-2474.

LAKELAND, FLORIDA: FOR SALE, 6% down. Air-conditioned office for one to three physicians. Main street, 168 x 140 ft.; double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

1973 NEW OFFICE BUILDING in medical complex, designed and furnished for two, 3100 sq. ft. One half available in July 1976. Contact Mrs. E. Pent (813-293-2147) 450 Avenue K, Southeast, Winter Haven, Florida 33880.

FOR RENT, WEST PALM BEACH: Unusually good central location on South Flagler Drive. New, one story building. Parking. Call (305) 655-8620, evening (305) 833-2952.

DESIRABLE SPACE AVAILABLE, ample free parking, janitor service, A/C, 440, 528, 1,104 sq. ft. 1333 S. Miami Avenue, Miami 33130. Suitable MD or other, reasonable terms. Manager on premises, Room 111. Phone: (305) 374-8210.

OFFICE TO SUBLET. Fort Lauderdale-Plantation area. Excellent location on major thoroughfare. Many extras. Available immediately. 1,345 sq. ft. Very reasonable rent (all utilities included). Phone: (305) 584-8050.

FORT LAUDERDALE. Three spaces left in new medical building. Two major medical groups present. Good location near two private community hospitals. Custom designed suites. Phone: (305) 584-8050.

PROFESSIONAL OFFICE FOR RENT: Altamonte Springs: Great location on Highway 436. Offstreet parking, 1,175 sq. ft. Contact George Culpepper, M.D., Route 1, Box 97 H, Longwood, Florida 32750. Phone: (305) 834-3700.

ACTIVE MEDICAL OFFICE adjoining large drug store in Southside Jacksonville for rent or purchase including drug store. For information call (904) 737-5390.

PROFESSIONAL OFFICE FOR RENT, 2250 South Dixie Highway. 4,000 square feet. 1 story brick. Off street parking area. 2,200 square feet exquisite 2 doctors' completely equipped suite, also 1,800 square feet remodeled to suit. Call (305) 856-5170, Miami, Florida.

NEW MEDICAL DENTAL BUILDING, W. Palm Beach. Two story rental building. Preconstruction prices for October 1976 occupancy. Located between 2 major hospitals. Butler Medical Center, 200 Butler St., Write: P.O. Box 462, Palm Beach, Fla. 33480. Phone (305) 585-6346 or 659-6277.

Classified advertising rates are $7.50 for the first 25 words or less and 25 cents for each additional word. Deadline is first of month preceding month of publication.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville, Florida 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

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International Doctors in Alcohol Anonymous Meet in Los Angeles

International Doctors in Alcoholics Anonymous (IDAA) has announced its 1976 convention will be held at the Los Angeles Marriott Hotel, August 5-8.

IDAA is a non-dues organization of physicians and dentists who get together at least annually to help each other obtain and maintain their sobriety and freedom from drugs, according to the Secretary.

Information may be obtained by contacting Secretary, International Doctors in Alcoholics Anonymous, 1950 Volney Road, Youngstown, Ohio 44511.

Florida Medical Association
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1976-1977

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Bradford (See Alachua)					
Brevard	Pat B. Unger, Melbourne	Richard Baney, Titusville	2nd Tues.	24	201
Broward	Thomas F. Regan, Hollywood	Ann M. Blenke, Ft. Lauderdale	4th Tues.	163	937
Calhoun (See Panhandle)					
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Charlotte	Charles M. Wilson, Pt. Charlotte	Stephen R. Roddy, Charlotte Harbor	3rd Mon.	1	55
Citrus-Hernando	Jorge O. Escamilla, Brooksville	Jose R. Berrios, Brooksville	3rd Thurs.	1	38
Clay	William Baxley, Gr. Cove Spgs.	Arthur D. Thaeler, Penney Farms	2nd Thurs.	1	30
Collier	Charles J. Montgomery, Naples	Charles Eytel, Naples	3rd Wed.	1	80
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Ortho Pharmaceuticals
Vermox 466-467

Pharmaceutical Manufacturers Assn.
Institutional 546-547

Psychiatric Institute of Mexico City
Institutional 580

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Librium Third and Back Covers
Valium 462, 463
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Index to Proceedings

A. H. Robins Award 488
Board of Governors Report 507
Certificates of Appreciation 526, 527
Certificate of Merit 526
Committee on Allied Health Professions 505
Committee on Voluntary Health Agencies 505
Distinguished Layman's Award 491
Council Reports
- Judicial 520
- Legislation and Regulations 528
- Medical Economics 534
- Medical Services 502
- Medical Systems 535
- Scientific Activities 493
- Specialty Medicine 497

Election of Officers 541
Florida Medical Foundation 519
Florida Physicians Association, Inc. 519
General Session 484
House of Delegates
- First House 486
- Second House 490
- Third House 524

President's Address 479
Reference Committee I 493
Reference Committee II 502
Reference Committee III 507
Reference Committee IV 528
Reference Committee V 534
Remarks of the Speaker 487

RESOLUTIONS

76-1 Equal Coverage for Mental Illness 538
76-2 CME Credit—National Specialty Societies 499
76-3 Binding Arbitration 532
76-4 FMA Headquarters Relocation 523
76-5 Establishment of Defense Fund Insurance Trust for Medical Liability Insurance Cases 523
76-6 Children's Medical Services Funding 532
76-7 Fourth Florida Medical School 499
76-8 Criteria for Medical Audit 538
76-9 Blue Shield of Florida 538
76-10 JCAH and Audit Posture 538
76-11 Hospital Insurance Level—M.D. 533
76-12 Hospital Requirement of M.D. Insurance 539
76-13 PSRO 24 Hour Review 539
76-14 National Health Insurance 533
76-15 Podiatrists' Hospital Staff Membership 506
76-16 Third Party Carrier Reimbursement for Tumor Registry Programs 539
76-17 Drug Package Inserts 533
76-18 School of Medicine of the Uniformed Services University of the Health Sciences 499
76-19 Third Party Carrier Reimbursement for Tumor Registry Programs 540
76-20 Professional Standard Review Organization 540
76-21 Nurse Practice Act of 1975 533
76-22 Mandatory Malpractice Insurance Coverage 539
76-23 Private Aircraft Travel Insurance Coverage 540
76-24 Primary Care 499
76-25 Blue Shield of Florida 540
76-26 Woman's Auxiliaries to County Medical Societies 523
76-27 Relative Value Studies 540

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido —all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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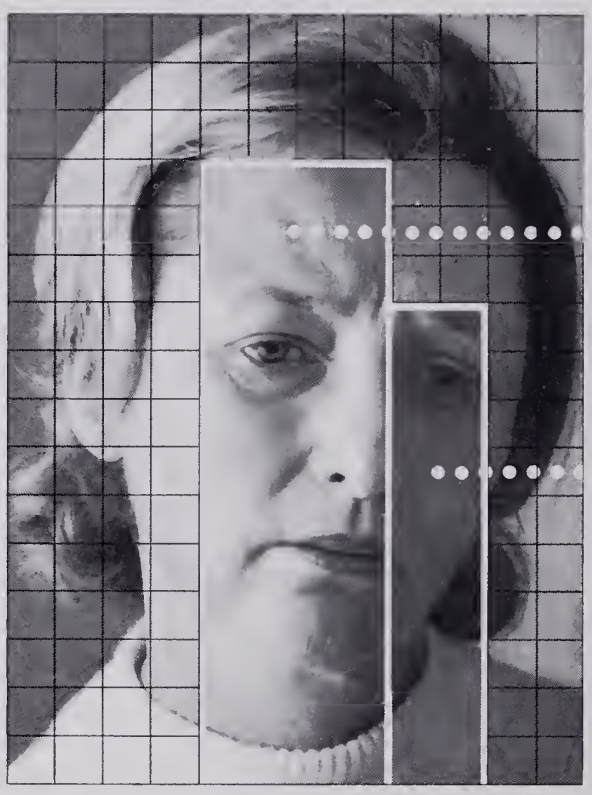


William M. Straight

GUEST EDITOR

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Associated depressive symptoms

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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1976 Historical Issue

Doctors and Disease in the British Floridas
William M. Straight, M.D. **611**
Edward Jelks, M.D.—
A Biography of Achievement
Linda C. Moseley **622**
Notes on the History of Leprosy in Florida to 1921
Joy S. Richmond, M.L.S. **631**
The Romantic Necrophiliac of Key West
Alvan G. Foraker, M.D. **642**

Special Articles

Pensacola Musical Medics Find Harmonious Way to Serve **647**
FMA Convention 1976—
A Student Delegate's Report
Joel K. Lipman **648**

Sections

President's Page
Jack A. MaCris, M.D. 597
Books Received 668
Book Reviews 666
Commentary
Letter of congratulations to Dr. Astler
Al Ogden, M.D. 662
Letter from Dr. Astler to Mr. Raymond J. Mariotti 662
Dean's Page
The Impact of Malpractice Costs on Medical Education
E. M. Papper, M.D. and
Bernard J. Fogel, M.D. 606
From the Editor's Desk
Gerold L. Schiebler, M.D. 602
Medical News Around the State 670
Organization
A Review of Florida's Comprehensive Medical Liability Law—1976
W. Harold Parham, D.H.A. and
John Thrasher, J. D 652
In Memoriam—Curtis W. Cannon, M.D.
Vernon B. Astler, M.D. 656
Florida's Dr. Francis T. Holland Elected AMA Vice President 657
Conference on Identification of Needs and Standards for Inhospital Critical Care
Arthur Trask, M.D. 658
Telephone Directory Specialty Headings for Members of the FMA 659
Others Are Saying
Undergraduates: Your Responsibility
Elliott Podoll, M.D. 651

Information

Classified Advertising 675
FMA Officers and Council Chairmen 678
Information for Authors 668
Index to Advertisers 678
Meetings 671, 672

August Cover — The map, supplied by Dr. William M. Straight, Historical Editor, is "Florida from the latest authorities by T. Jeffery, Geographer to His Majesty, c 1763." From the N. B.T. Roney Map Collection of the University of Miami.



President's Page

"There are two things an outsider shouldn't watch being made, sausage and the law." Fortunately, I watched only the later, so I still enjoy sausage. The legislative process is truly bewildering to one not knowledgeable about the workings of the bicameral legislature. Yet, out of this seeming confusion, each year come the laws by which we citizens in Florida live.

The past two legislatures have passed a number of laws concerning the professional liability problem, some we requested and are pleased with, others we did not request and are not pleased with, and some we did not request and cannot evaluate until we have some experience coping with them. Regardless of how one evaluates these many laws, I think it is important to point out one observation. The legislators recognized that a serious problem existed and that the public was concerned about it. They made a conscientious effort to help solve the problem, taking into account that more than one point of view existed on many of these matters.

All in all, the legislative package was a victory in the sense that a major portion of our requests was enacted into law and we are hopeful that this will help control the skyrocketing cost of liability insurance. This legislative support should not be misconstrued as warm affection for doctors or organized medicine. We went to Tallahassee with a problem threatening our patients and our being permitted to care for them, and a legislative request that we thought would help the problem. We had a just cause and an unselfish motive and our legislators responded. We are now anxious to see these new laws in use, hopefully to accomplish their intended ends.

The risk management law is a law not requested or sponsored by the FMA. The risk management concept became law last year for hospitals over 300 beds in size. This year's law extends it to all hospitals and spells out more specifically how it shall be implemented. Aspects of the law, such as the risk management committee having the authority to commit funds of an insurance company, are questionable. However, its boosters, among whom are hospitals actively using this concept, are convinced that this approach does reduce the number of suits which go to court and the cost of liability coverage overall. Since this is now the law, we sincerely hope this is true.

We are now hopeful that the FMA-PLI Trust will survive. It has had eight months of life and an unbelievable amount of progress has been made. It is already expanding its horizons. We are hopeful that PIMCO can establish a risk management consulting service for hospitals. Further, it is hoped that the trust can become a mutual company next year. This will eliminate the assessability of the trust membership. Already, ophthalmologists' rates have been reduced, based on a review of past experience preceding the trust.

This is a period of optimism following a period of impending disaster. It is made possible by the concerted effort of a relatively small number of physicians, members of FMA staff, and a group of professional people hired in Tallahassee to help us. No matter how devotedly the first two groups toiled, without the expertise of the last group, we could not have accomplished what we did.

Jack A. Willis, M.D.

A review of Florida's Comprehensive Medical Liability Law 1976 appears on page 652.



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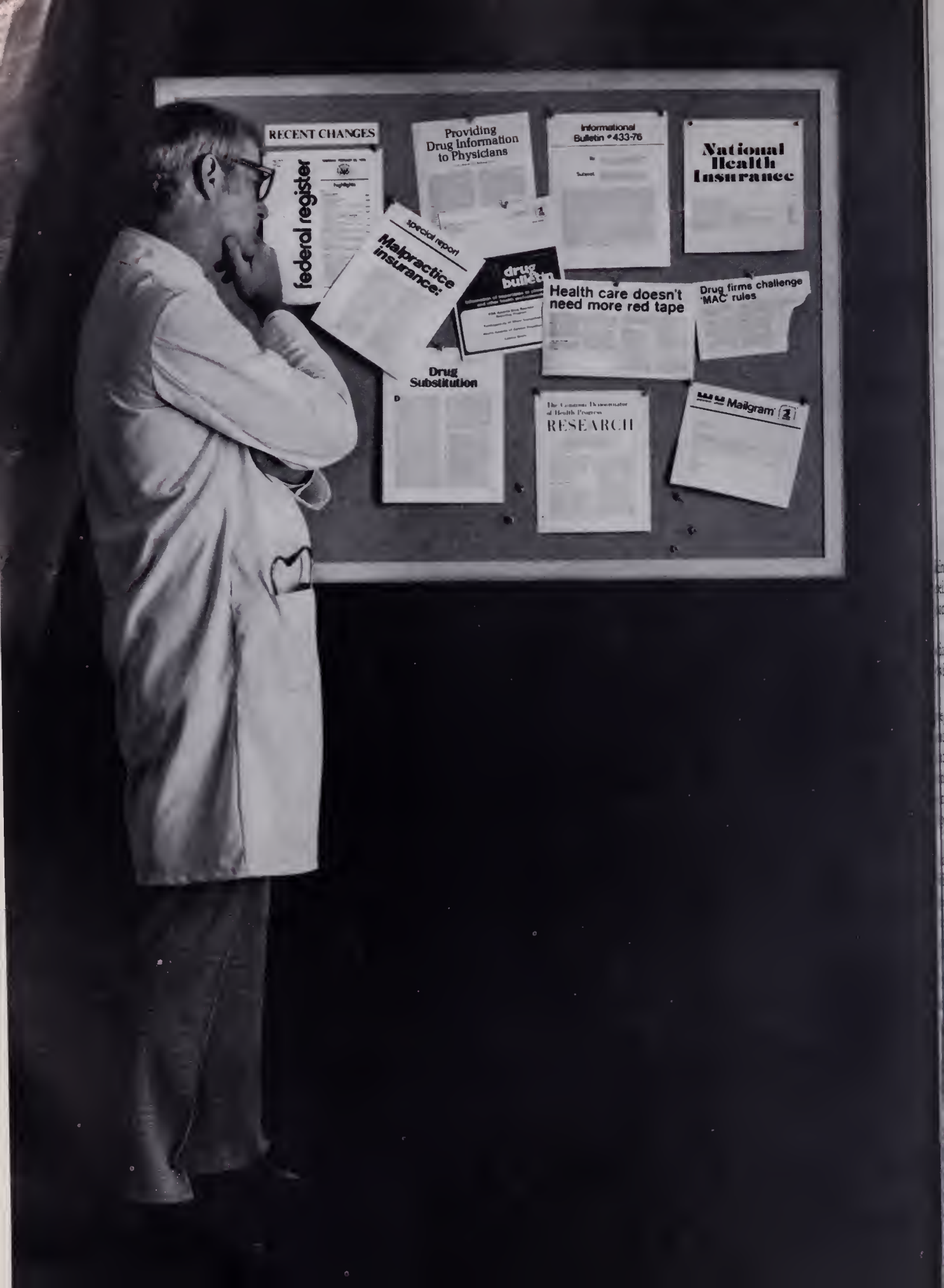
Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all nds of scrutiny. Your control over patient therapy is ing monitored, judged and occasionally abrogated, metimes by unknown third parties.

The worry is that in the wake of this focus, the relaonship between you and your patient will be weakened, ithout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, gulations or professional custom stipulate that your n-generic prescriptions be filled with the precise prodts you prescribe. But in the last five years, a dozen or ore State laws have been changed, permitting the pharacist in most cases to select a product of the same neric drug to fill any prescription.

Ironically, this dilution of physician control has ken place against a background of growing evidence at purportedly equivalent drug products may be inquivalent, since neither present drug standards nor their forcement are optimal. In fact, the FDA itself says it s not enforced the same standards for hundreds of ollow-on" products that it had applied to the original DA approvals. Thus physician control over patient erapy is being eroded with a risk that patients may be posed to drugs of uncertain quality.

The major advertised claim for substitution is reduced escription prices for consumers. Yet no documentation any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's ug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber rtifies on the prescription that a particular product is edically necessary, the Government intends to pay only r the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



FROM THE EDITOR'S DESK

As Editor and Chairman of the Committee on Scientific Publications, our energies have been focused on recruiting material for these columns and in getting as many physicians as possible involved with the publication of The Journal.

It has been suggested that a monthly column be initiated that would cover a panorama of topics of interest to many FMA members. Such a column would report on specific activities of FMA, AMA and other medical affairs and important events in the lives of our members.

In recent months the following items of interest have crossed the Editor's desk . . .

Seven of Florida's nine Health Service Areas (HSAs) have received partial federal funding. Health Systems Agency of South Florida, Inc., of Miami, (HSA #9) receives $282,000. Receiving $192,000 is Health Systems Agency of East Central Florida, Inc., of Orlando, (HSA #5). Others, receiving $175,000 each are: Florida Panhandle Health Systems Agency, Inc., of Panama City (HSA #1); North Central Florida Health Planning Council, Inc., of Gainesville (HSA #2); HSA of Northeastern Florida Area III, Inc., of Jacksonville (HSA #3); South Central Florida Health Systems Council, Inc., of Winter Haven (HSA #6); and Health Planning Council, Inc., of West Palm Beach (HSA #7) . . .

* * * * *

Teams of investigators have begun, or will begin soon, looking into possible Medicaid fraud and abuses in Ohio and Massachusetts. HEW plans to urge health provider organizations to initiate self-policing programs and to assist states in identifying potentially fraudulent providers . . .

* * * * *

Former HEW Assistant Secretary for Health Charles Edwards, M.D., predicts that the nation's health bill next year will average out to $600 per person. The health care system, he told a Washington conference on the economic impact of health care legislation, is headed toward basic changes that will come about sooner than expected. Speaking at the same meeting, AMA Past President Malcolm Todd, M.D., predicted that any of the national health insurance programs now before Congress would result in greater utilization, and thus increased costs.

* * * * *

A claim against the state with potential widespread implications has been rejected unanimously by a subcommittee of the Florida House of Representatives. Claiming that the Florida Board of Medical Examiners was negligent in failing to discipline her physician for alcoholism, cancer patient Shirley Spillman McClain, formerly of Orlando and now of Ohio, sought an award of $400,000. Her attorney said Dr. Robert Thomas, who has since moved out of state, diagnosed her as pregnant but it turned out she had an ovarian tumor. Attorneys for the BME argued that the Board had set the proper hearing procedures in motion but lacked authority at that time to suspend Dr. Thomas' license . . .

* * * * *

Our congratulations to FMA Immediate Past President Vernon B. Astler, M.D., who recently was accorded resident membership on the Florida Council of 100. He has been assigned to a seat on the Council's Health Care Committee.

* * * * *

The new President of the Florida Physicians Association, Inc., is St. Petersburg internist David T. Overbey, M.D. Dr. Overbey succeeds James T. Cook, M.D., of Marianna, who headed the organization since its founding a few years ago and decided to bow out this year. Dr. Overbey will be assisted by Vice President John A. Dyal, M.D., of Perry; Secretary J. Gerard Converse, M.D., of Winter Haven; and Treasurer Warren Barrett, M.D., of Jacksonville.

* * * * *

Pensacola psychiatrists, always active in organized medicine, have scored again with the elevation of Philip B. Phillips, M.D., to the office of President-Elect of the Florida Psychiatric Society. A regular contributor to The Journal, Dr. Phillips is well-known in the FMA House of Delegates for his perennial eloquent and humorous nominating speeches for fellow Pensacolian, Charles J. Kahn, M.D.

Retail prices of prescription drugs rose 6.6 per cent last year, according to the Pharmaceutical Manufacturers Association, which blames the increase on "sharp inflationary cost increases in raw materials." In the past two years, PMA adds, drug prices have advanced at half the rate of wholesale prices of goods in general.

* * * * *

"M.D. is the Major Difference." That's the slogan of the new "Ophthalmic Physicians Education Network (OPEN)." Organized for the "protection of the general public" by the Florida Society of Ophthalmology, OPEN publishes a newsletter and is engaged in other activities. Several ophthalmologists were on hand to help when the Lions Eyemobile visited the Capitol in Tallahassee for glaucoma screening. First in line was Commissioner of Education Ralph D. Turlington.

* * * * *

AMA has decided to join the State of North Carolina in its lawsuit contesting the constitutionality of the Health Planning and Development Act. (93-641). Filed at Raleigh, the federal suit maintains the law requires states to pass certificate-of-need legislation, which has been branded unconstitutional by the North Carolina Supreme Court.

* * * * *

After a thorough investigation precipitated by an anonymous informer, the U.S. Postal Service has concluded that AMA is entitled to continue mailing at special second and third-class rates. In mid-1975 a snitch known as "Sore Throat" passed information to newspapers in an apparent effort to get AMA in trouble with the postal authorities and the Federal Elections Commission.

* * * * *

The legal profession may produce solutions to the malpractice crisis when enough of its own members get sued. That's the conclusion of the **Washington Post**, which took note of a sharp rise in the number of law suits against lawyers. Said the **Post:** "Once the lawyers realize that they could become as vulnerable as the doctors now are to huge malpractice verdicts, the legal ingenuity that has helped to create the malpractice problem may, at long last, be redirected to help solve it."

* * * * *

After a study of four national health insurance proposals, Rand Corporation has concluded there would be little difference among the four in impact on families earning more than $9,000 a year. This similarity, the report speculates, might enhance compromise on the question of whether national health insurance should be administered by government or private enterprise. Studied were the Administration's old Comprehensive Health Insurance Program, Kennedy-Mills of 1974, the current Kennedy-Corman approach, and the Long-Ribicoff catastrophic proposal.

* * * * *

AMA has asked Congressman John E. Moss of California to reopen his hearings on "unnecessary surgery." The Subcommittee on Oversight and Investigations, which Moss chairs, reported that Americans spent $3.9 billion on 2.3 million unnecessary operations that resulted in 11,900 deaths. AMA contends the Subcommittee used improperly a study by Eugene McCarthy, M.D., of Cornell Medical School, thus resulting in invalid conclusions. AMA suggested that Dr. McCarthy be recalled as a witness at new hearings.

* * * * *

AMA Judicial Council has clarified and reaffirmed long-standing policy on advertising and solicitation of patients. The Principles of Medical Ethics do not proscribe advertising, the Council said, but they do proscribe the solicitation of patients. To furnish information to the public, physicians may use such media as office signs, professional cards, dignified announcements, telephone directory listings and reputable directories. The Council said the information could include the doctor's name, type of practice, office location, office hours and other information "that will enable people to make a more informed choice of physician."

* * * * *

A tip of the editorial hat to James J. Cerda, M.D., recipient of this year's Hippocratic Award for Teaching Excellence, which is given by the graduating class at the University of Florida College of Medicine. Dr. Cerda is Associate Chairman of the College's Department of Medicine.

The Editor

JUST ONE CHEWABLE TABLET

usually eradicates pinworms in both children and adults



No dosage calculations

Vermox (mebendazole) offers a greatly simplified method of treating pinworm. Just one tablet, for every member of the family, regardless of weight or age.†

Simplicity of administration

Patients can take the tablet at any time. It can be chewed, swallowed, or crushed and mixed with food. No messy liquids to pour.

Not a dye

Vermox will not stain clothes, teeth, feces, toilet bowls, etc.

Highly effective

In clinical studies, the pinworm mean cure rate with Vermox was 95% (range 90-100%). In cases where reinfection occurs, a repeat tablet is advised.

Well tolerated

Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Also effective against whipworm...as well as roundworm and hookworm

Just one simple dosage, regardless of weight or age,† for single or mixed infections: 1 chewable tablet b.i.d. for 3 consecutive days. If the patient is not cured 3 weeks after treatment, a second course of treatment is advised.

†Because Vermox has not been extensively studied in children under 2 years of age, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

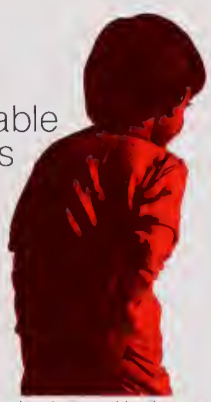
a single chewable tablet treatment for pinworm

Vermox

chewable tablets

TRADEMARK

(mebendazole)



DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. An insignificant amount of mebendazole is absorbed from the gastrointestinal tract. Most of this is excreted in the urine within three days either as metabolites or unchanged drug.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.

Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates mean (range)	68% (61-75%)	98% (91-100%)	96% –	95% (90-100%)
egg reduction mean (range)	93% (70-99%)	99.7% (99.5-100%)	99.9% –	– –

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE The drug has not been extensively studied in children under two years, therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium, and co-developed by Ortho Pharmaceutical Corporation.

Ortho Pharmaceutical Corporation
Raritan, New Jersey 08869

OJ 175-6



Dean's Page

The Impact of Malpractice Costs on Medical Education

E. M. Papper, M.D. and Bernard J. Fogel, M.D.

It is recognized by all practicing physicians that the cost of malpractice insurance has escalated uncontrollably in recent years, if it was available at all. Although the problem first surfaced on the West Coast, it spread nationwide immediately. As insurance policies for physicians and institutions came up for renewal, the annual premium rates skyrocketed 300% to 500% over prior years. Often it was not available at any price. These prohibitive costs have reflected the purpose of the insurance industry to withdraw from the malpractice field.

Although the increasing rates reflected the malpractice claims losses for the entire nation, they impacted on some states worse than others. Florida in particular was hard hit. This State, whose academic institutions have always had excellent records in maintaining high quality review and standards of practice with correspondingly low malpractice claims rates, found that they could no longer protect and indemnify themselves adequately in the usual ways. Although much has been written on this complex subject, little has been said about the impact of the malpractice situation on the medical schools' ability to provide a quality education to undergraduate and graduate students as well as to meet commitments for community service and biomedical research. More also needs to be put before the public on the enormous escalation of health care costs produced by this unacceptable problem.

On the one hand, the federal government has encouraged medical schools to decentralize training programs and to collaborate with community hospitals and health foundations. A major objective of much of the health manpower legislation which has been enacted during the past decade has committed medical schools to admit greater numbers of medical students and house officers in the rural areas, and for primary care functions. To do so, the medical schools affiliated with a large number of hospitals, physicians, and other health related facilities and established networks of teaching programs. Unfortunately in the light of the present malpractice situation, most medical schools cannot send their house officers to affiliated institutions which cannot properly defend and indemnify the housestaff officers because they are incapable of purchasing adequate malpractice coverage or otherwise protecting the parent institution from lawsuit and judgment. Medical schools are being forced to withdraw their students from programs over which they do not have direct control—despite the professional and educational advantages because of financial risks of the malpractice problem.

Another consequence of the malpractice issue is the closing of many free community service programs which were previously manned by undergraduate medical students and house officers. To be specific, the University of Miami School of Medicine opened in conjunction with the Department of Family Medicine, a Monday Night Women's Clinic to provide services at no charge to patients who might otherwise not receive care. The loss of adequate malpractice coverage by the medical school forced the administration to notify the students that they were not protected when providing needed community services. This meant that the students were denied the right of an excellent educational opportunity under the supervision of either house officers or faculty who volunteer their time to provide service in these free clinics; and patients in need were deprived of their services.

Another important aspect of our educational program which is impacted negatively is that of permitting medical students to rotate for clinical

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, and Dr. Fogel is Assistant Vice President for Medical Affairs, University of Miami School of Medicine, Miami.

training to other medical schools throughout the country and to receive students from other Schools of Medicine. In the past, medical schools have exchanged senior students freely. This practice permitted students the opportunity to observe and evaluate other institutions of higher learning in terms of teaching as well as internship or residency programs. Because medical schools are increasingly forced to self-insure and are unable to obtain adequate malpractice protection, they can no longer enjoy the privilege of inviting students from other schools for externships nor can they send their students elsewhere for similar educational experiences without serious financial risk.

Finally, a point which is well recognized by the medical profession must be reiterated. That is the fact that the physicians' concerns about lawsuits have resulted in expensive medical care and illogical role models as teachers of medicine. It is estimated that the cost of medical care in this country has increased between 15% and 20% because of the malpractice cesspool. It would be unfortunate if the medical schools had to include "defensive medicine" in their curricula. We would be teaching as bad medicine as is practiced by the ballooning costs of unnecessary tests and procedures.

Unfortunately, there are no simple answers to this unprecedented and destructive problem. It is important to recognize that the impact of the malpractice insurance issue has not been solely on patient services. It is being dramatically felt in the medical schools' educational and biomedical research activities. It is a problem of high dimensions that demands solutions of statesman physicians in changes of public policy.

▶ Drs. Papper and Fogel, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

"We Must Encourage More Physicians to Seek Public Office"

Of its 140 members, the Virginia General Assembly has 83 lawyer-legislators—and only one physician-legislator. He is Senator John C. Buchanan, M.D., of Wise, an internist and Democrat, recently reelected to his second term. Senator Buchanan is highly respected by his colleagues in the Assembly; he is noted for his knowledge of the law and for his talent for clarifying and simplifying bills. A native Virginian, he is 65 years old.

The state of Florida has elected four physicians to its legislature; one is a senator and three are representatives. Their pictures are on the cover of a recent issue of the **Journal of the Florida Medical Association,** a splendid state journal received by a membership of over 10,000 doctors. Its editor is Gerold L. Schiebler, M.D. He editorializes on the physician-legislator as follows:

". . . we must encourage more physicians to seek public office, enter the legislative forum, and then make it possible for them to remain in the legislature long enough to garner legislative strength. Think of the effectiveness of our present four! Think also of the sad state of our legislative thrust if we had no physicians in the Florida legislature.

"Consider the position of our professional counterparts, the lawyers: 1) they have traditionally sought public office, so that 25-60% of each House may at any time be composed of lawyers; 2) their training is better designed to adapt to the legislative process; 3) laws promulgated by them will affect individuals who will be prosecuted or defended by them or their colleagues; 4) laws, when appealed, will be interpreted finally by lawyers sitting as judges on some court; and 5) the final governing body of the legal profession in Florida is the State Supreme Court—the members of which are all lawyers—with that body being a co-equal with the legislative and executive branch in State government.

"Should not the physicians be entitled to a parallel structure, with our State Board of Medical Examiners being tantamount to our Supreme Court on medical matters, or should we petition to have physicians placed on the Supreme Court itself?"

Reprinted from the Virginia Medical Monthly, June 1976.



Just what is Florida Drug Utilization Review all about?

Drug Utilization Review is part of the Medicaid drug program in your state. The goal is to assist in the delivery of rational drug therapy for Medicaid patients and reduce the over all cost of the Medicaid drug program.

How can Drug Utilization Review do that?
It is done by reviewing Medicaid drug use and sharing the results of the review with those doctors and pharmacists involved in treating the patient. When a Medicaid prescription claim is processed, a computer records who received the drug, who prescribed it, who dispensed it, and what kind of drug it was. Once a month, the computer compares the drug use records of each patient with several criteria, such as kinds of drugs used, amounts purchased, number of doctors visited, and so on.

When a patient's drug use goes beyond any of the criteria, the computer prints a report for review by the Drug Utilization Review Committee.

Just who is the Drug Utilization Review committee?
It is a group of fellow health care professionals—physicians and pharmacists from your area. Committee members are selected from nominations made by your local medical and pharmaceutical associations. Each member serves for 1 to 3 years. You may be invited to serve on the committee at some time.

What does the Drug Utilization Review committee do?
The committee reviews patient drug histories showing drug use patterns which exceed criteria set for the program. If the questionable pattern appears to be minor or temporary, the committee may decide to take no further action.

If the situation is more serious, the committee will write to the doctors and pharmacists involved to advise them of the potential problem. For example, the records might show that a patient is going to several doctors to get prescriptions for the same drug. The committee would advise each of the doctors of this practice. In another case, the committee might recommend that a doctor prescribe maintenance drugs in larger, more economical quantities, if the patient's condition warrants it.

Are you trying to tell me how to treat my patients?
Not at all. Your patients' treatment is in your hands, where it belongs. All Drug Utilization Review does is give you information about your patients' drug use that hasn't been available before. The committee can't dictate the kind of drug therapy you use, and wouldn't want to if it could.

What do I have to do if I get a letter about a patient?
The committee will ask you to review your records to see if the situation described in their letter is with your knowledge and conforms with your diagnosis and treatment. If so, please advise the committee of your diagnosis and treatment plan so they'll know that the drug use is appropriate and won't send additional letters in the future.

If the situation is not called for by your treatment plan, the committee asks that you review the situation and make those changes you feel are necessary. In all cases, they try to make it as easy as possible for you to respond to the committee and use the information provided.

How can a physician find out more about the Drug Utilization Program?
A pamphlet which explains the Drug Utilization Review program in detail is available or a visit to your office by a staff member can be arranged upon request. A speaker or a color/sound film can also be provided for local medical societies or other groups interested in further information about the program. Your peers who are members of local peer review committees will be glad to explain the program personally or answer any questions. If you will write or call PAID Prescriptions, any information requested will be provided including the names of committee members in your local area.

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INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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1976 Historical Issue

Doctors and Disease in the British Florida's

William M. Straight, M.D.

In the Seven Years War (1755-1763) England doubled the size of her empire by taking Canada from the French and Havana and Manila from Spain. In the Treaty of Paris which ended that war Britain traded Havana for Florida and thus extended her holdings on the North American continent from the tip of Florida to the arctic. Florida then included all of present-day Florida and the southern portions of Georgia, Alabama, Mississippi and Louisiana "except the Isle of Orleans." New Orleans and extensive lands west of the Mississippi which had been French, became Spanish. England divided Florida at the Apalachicola River into the provinces of British East Florida, with the capitol at St. Augustine, and British West Florida, the capitol at Pensacola.

The transfers occurred in July and August of 1763 and during that fall British troops established garrisons at the capitols and outposts at Iberville, Manchac, Mobile, Natchez and St. Marks. Counting whites, blacks and Indians, free and slave, the population at the time of the transfer was small: 3,046 at St. Augustine, less than 800 at Pensacola, and 350 at Mobile.[1]

In the methodical British manner an administrative system was established and development of the land was encouraged. Large land grants were awarded by the Privy Council in London to gentlemen of means and by the governor and council in Florida to heads of families on the condition that they would make the land productive. Among the most famous of these land holders was a London practitioner, Andrew Turnbull, who with two London merchants received some 60,000 acres south of St. Augustine on which they established the New Smyrna colony. At their own expense they brought 1,255 colonists from Minorca, Greece and Italy. The first of these arrived in June, 1768, and after many hardships the colony began to prosper. However, dissension arose and finally, in the spring of 1777 the colony was largely abandoned and the settlers moved to St. Augustine.

The single event which had the greatest impact on the British Floridas was the outbreak of the Amer-



Fig. 1.—Andrew Turnbull, M.D. (Courtesy of Carita Doggett Corse).

ican Revolution. Both East and West Florida remained intensely loyal to Great Britain and became havens for the Loyalists who fled the rebellious colonies as well as staging areas for launching attacks on the southern colonies.

On November 2, 1775, Governor Patrick Tonyn of East Florida issued a proclamation offering grants of land and assistance to Loyalists who wished to settle in Florida. This brought a modest influx of settlers and when the British Parliament voted to cease hostilities against the American colonists in 1782, a second and much more voluminous influx occurred. In less than a year the population of East Florida more than quadrupled.

Since many of the Loyalists arrived destitute, the sudden swelling of the population resulted in shortages of food, clothing, housing and farm tools. However, it also brought people to settle and work the land, cut the timber and box the pine trees for turpentine. Among the refugees were artisans, tradesmen and professional men. In consequence the exports of lumber, naval stores, animal hides and various farm products rose sharply. A new town grew up on the south bank of the St. Johns River, six or seven miles from its mouth. This town, known as St. Johns and St. Johns Bluff, grew from a single settler in 1771 to 1,500 people in the early 1780's.[2]

In June, 1779, Spain declared war on England and about eight months later Bernardo de Galvez captured Mobile. Then on May 8, 1781, he captured Pensacola and Spain acquired British West Florida. Some two and a half years later, February, 1783, England ceded East Florida to Spain and most of the hapless Loyalists moved again. About 10,000 went to the Bahamas, West Indies, Nova Scotia, England and other shores. Four thousand disappeared into the sparsely settled lands west of the thirteen colonies and about 3,000 returned to the American colonies and made their peace with the victors.[2] Although the Spanish governor, Manuel de Zespedes, assumed office in East Florida on July 12, 1784, Governor Tonyn remained until November 19, 1785, to supervise the British departure.

Disease and Death

A German physician-naturalist who traveled in East Florida at the end of the British period tells us: "East Florida, as regards sickliness, has often been judged with the same disfavor which experience attaches to the southern parts of North America generally; but without reason. Augustin itself is widely known to be a healthy place, so that weaklings and consumptives from the northern provinces resort hither, and always to their advantage."[3]



Fig. 2.—Plan of the Town and Harbour of St. Augustin 1782. (Courtesy of the Library of Congress).



Fig. 3.—(Courtesy of the Library of Congress).

As we will see East Florida was healthy in comparison with West Florida but it was not without illness. For example, the King's surgeon at St. Augustine, Robert Catherwood, writes: "In the latter end of 1765 and the Spring of 1766 this Garrison (being Havannah Convalescents) was so extremely Sickly it was with difficulty they could mount a Serjeants Guard; The reason of such number falling sick was owing in a great measure to the want of Bedding in the Barracks it being an extraordinary Wet Spring and Fall."[4] Another example of disease comes from the ill-fated New Smyrna colony. The colonists arrived sickly after a four months sea voyage and by December, 1768, about three hundred had died from sickness.[5] One of the chief causes of these deaths was scurvy which in the words of Governor James Grant, ". . . brings in Gangrenes mostly in the mouth. When their Gardens are got into Order 'tis to be hoped vegetables will effectually remove the bad Effects of a long and tedious Voyage from the Mediterranean."[6]

In the first two years of their stay in Florida, 627 of the New Smyrna colonists succumbed to scurvy, malaria and other diseases and accidents. When in 1777 the colonists abandoned New Smyrna and moved to St. Augustine, an undefined illness broke out among them and dispatched another sixty-five in the course of two months.[7]

Our sources of information about disease in West Florida are somewhat more extensive than those of East Florida. These have been carefully studied by Laura D. S. Harrell, Robert R. Rea and Jack D. L. Holmes. From reports of civil and military officials and a vicar's burial record we learn the following dismal statistics. In the two year period, 1765-1767, six officers and one hundred ninety men, five officer's ladies, and twenty-three other women died.[8] During the year, 1768-1769, there were forty-nine deaths in Pensacola and in the year, 1769-1770, (a year in which the population of Pensacola had been sharply reduced by troop withdrawals) fifteen deaths.[9] The year, 1770-1771, brought fifty-three deaths at Pensacola.[9]

After 1771 we have no mortality statistics but the military reports indicate that sickness frequently prevailed. Thus in September, 1779, General John Campbell reported to Sir Henry Clinton: ". . . By the last Returns there are no fewer than 160 Non-Commissioned Officers and Privates Sick under Colonel Dickson's Command, 45 Ditto at the Red Clifts near the Entrance of Pensacola Harbour 70 Ditto at Mobile, and 97 Ditto at Pensacola making in all 372 men and the sickness at that Time was represented as increasing rather than Diminishing . . ."[9]

Dr. John Lorimer, surgeon to the military hospital at Pensacola (1765-1781) described the sequence of diseases that plagued the province in 1769: "The bilious, remitting and intermitting fevers then set in, and continued by repeated relapses throughout the months of July, August, and September . . . At the approach of the cold weather, the fevers abated, and they then fell into fluxes, dropsias, and cachexies."[9,10]

Other diseases mentioned by various writers as being seen in the British Floridas are: asthma, catarrhal fever (upper respiratory infections and tracheobronchitis), cholera morbus, convulsions, dry belly-ache (possibly appendicitis, diverticulitis, etc.), hydrophobia, lockjaw, nervous fever (typhus or typhoid), pleurisy, peripneumony (pneumonia), putrid sore throat (diphtheria and scarlet fever), scurvy, smallpox, sunstroke, venereal disease and worm fever (parasitic infestation). Also mentioned are deaths from accidents, excessive drinking, homicide, suicide and starvation.

Therapeutic Measures

Only meager details of the treatments administered to Britons in eighteenth century Florida are available. However, we do have lists of medicines requested for the use of troops in West Florida. One such list, compiled in August, 1764, is given in detail by Harrell:[9]

Camphora.
Cera flava.
Cortex Cinnamon.
Elixir Paregoric
Flor. Chamomel.
_____ Sulphur.
Magnesia alba.
Manna.
Olea Chym.
Pulvis Cortic. Peruvian.
_____ Jallap.
_____ Radic. Ipecacuan.
_____ Rhabarb.
Radex Gentian.
Sal carthartic. amar.
_____ Glauber. miral.
semen Lini.
spiritus Vini retificat.
Tinctura Thebaic.
Unguent. Basilic.
_____ dialth.
_____Mercurial fort.
_____ alb.
Virtum ceret antimon.

These drugs are to be found in the supply table of the British Army in the eighteenth century and by referring to a commonly used military medical text of that day[11] we can determine their use.

Fevers of all types were initially attacked by more or less vigorous blood letting. After phlebotomy, in the intermittent fevers four or five grains of ipecacuanha and from one half grain to two grains of emetic tartar were given. This was repeated in two hours and was expected to result in both a puke and a purge. At times twelve grains of crabs-eyes, a calcium carbonate concretion taken from the European crawfish, were given in addition. Following these measures the sovereign remedy, "the Bark," (Pulvis Cortic. Peruvian; i.e., quinine) was resorted to. For treatment, a wine infusion of the bark was given daily and as a preventive, an ounce of the powdered bark in equal parts of brandy and water were given every ten or twelve days throughout the autumn.[11]

The bilious remitting fevers were first treated with a gentle purge using Glauber's salt (Sal Glauber. miral.; i.e., sodium sulfate). Then within a few hours of the onset of fever, vigorous bleeding was performed. Later, if the fever failed to abate, blisters were applied and laudanum (Tinctura Thebaic.) was given. After the fever subsided gentle emetics (Pulvis Radic. Ipecacuan.) and salt of wormwood (Absinthe) dissolved in orange, lemon or lime juice were administered.

For the Jail or Hospital fever the patient was removed from the foul air or the air was purified by steams of vinegar. Early in the illness a puke was produced with tartar emetic and a sweat with spiritus Mindereri (acetate of ammonia). These were followed by a concoction of the Bark and Virginia Snake-root. If the patient became delirious, blood was let by the use of three leeches applied to each temple.

For the treatment of the fluxes Pringle quotes a Dr. Huck, ". . . who having been in constant service either in N. America, or in the W. Indies, had the best opportunities of seeing the dysentry . . ," as frequently purging with Manna or Glauber's salt every three or four days. If the patient passed into a stage characterized by hectic fever, much griping and small slimy stools, sal catharticus amarus and enemas of linseed (semen Lini), starch or mutton fat to which laudanum had been added were recommended. Also used for the flux were antimony (Virtum ceret antimon.) and solutions of yellow wax (Cera flava.).

The single instance in which we have precise details of a treatment is cited by Rea and Holmes.[12] Dr. Lorimer and others were consulted about the treatment of a Spanish lieutenant who had been seriously wounded in the attack on Pensacola, May 6, 1781. They recommended that the patient be moved to a clean, cool room and that, "The Patient should be frequently shifted with clean linen, which should first be well air'd"; that his wound be "wip'd clean & dressed with finest dry Lint, over which a warm poultice made of oatmeal softened with olive oil should be applied & these dressings renewed twice a Day"; warm baths should be used to relieve spasm; opium was to be continued with an equal quantity of Mosel wine; a strong decoction of the Peruvian Bark was to be administered, a half a pint every hour or as often as the lieutenant's stomach would bear it; and the patient should be nourished with "light Broths, his strength supported with a glass of generous wine[13] three or four times a Day, & his body kept open with Emollient clysters."

Preventive Medicine and Public Health

The preventive medicine and public health measures of the day were largely based on the miasmic theory of disease: the concept that particles, atoms or animalcules, ". . . arise from distempered, putrefying or poisonous bodies, and affect people at a distance."[14] Thus in March, 1767, Brigadier General Frederick Haldimand ordered the high pallisades of the fort at Pensacola moved further from the barracks to permit the freer circulation of air, the draining of the swamp behind the town, the construction of privies and the provision of a better water supply. At Haldimand's request Dr. Lorimer

offered further suggestions including the construction of barracks with sleeping quarters on the second floor, the boiling of drinking water in "vessels of tin or iron, for copper will not do in this climate," the assigning of fishermen to provide food from the sea, and the trading of the regulation issue of salt meat to the Indians for wild fowl and venison. He adds, "But as the soldiers must live upon salt meat after all, mustard & veniger or sour-crout ought to be procured & serv'd to the messes."[8,15] Recognizing that disease was more common among new arrivals, Lorimer recommended that troopships be dispatched: ". . . about the last of October, when that Climate is healthiest & the heat most supportable to an English Constitution. . . . By this means they may land at this place about the last of November or beginning of December, when this climate is much about the same temperature with England at the time they leave it. They will have a short agreeable winter before them, & be seasoned to the country next spring in the most gradual manner possible."[8]

Isolation was practiced at times for in March, 1767, when new troops arrived ill in West Florida, they were landed on Santa Rosa Island and detained there until their health returned.[8] Again in May, 1769, when smallpox became epidemic at Pensacola, the Lieutenant Governor issued a proclamation that all poor persons might apply to be taken to Santa Rosa Island and there be nursed back to health at the expense of the government.[16]

Similarly in East Florida Dr. Catherwood tells us: "Transports have at two different times come into this Harbour the Small Pox on Board; The infected Patients were sent over to the Lookout House on the Island St. Anastasia by Governor Grant's order, and Bedding furnished them were afterwards burned to prevent the Infection spreading, which might have been of fatal consequence not only to the Troops but to every Inhabitant of this Infant Colony."[4]

Inoculation (variolation) for the smallpox, in widespread use throughout colonial America, was also practiced in the British Floridas. In a letter from Robert Adair of the British War Office in London criticizing Dr. Catherwood for his profligate spending of the King's funds Adair states: "To begin with the Charge for inoculating 36 Soldiers, The Expence is L 63,3,8 — It is well known that Water Gruel with Bread pudding is the only proper Diet for patients under that Operation. For what purpose then can such a Quantity of Wine have been expended, to say nothing of four Gallons of Rum, the same Quantity of Brandy, ten bottles of sweet Oil, with Spices of every kind & 172 pounds of Sugar? . . . I will maintain that in this country the same number of Men might be carried through that Operation for as many Shillings as you have charged Pounds."[17] The letter goes on to imply that the inoculated men were isolated on an island, possibly Anastasia Island, for the duration of their infectiousness.

A glimpse of other preventive medical concepts of the day is afforded by a pamphlet compiled by a "Board of Military and Medical Officers who have served in the West Indies and in the Southern Provinces of America." Among many recommendations are: ". . . none of the Men should be quartered (if possible) on Ground Floors. The Men should sleep in Hammocks, or Cot-frames with Legs. . . . Should the Troops be encamped, it would be material for the Preservation of their Healths, to have the Tents boarded, as Straw is not to be had in that country. . . . Bathing in the Sea, with proper Precautions, may be considered as highly Salutary. The Men should not remain in the Water longer than Five Minutes, and they should not bathe oftener than three Times a Week; the best Time for bathing is early in the Morning. . . ." The pamphlet goes on to recommend that flannel be worn next to the skin for if a man sweat from exertion and become exposed to a cool breeze, ". . . it is Very probable he will cool too fast; it is pleasing to the Sensation, but very dangerous to Health. A Fever is a sure Consequence of the Pores being closed. . . . Flannel preserves a Warmth on the Skin, it is therefore beneficial. . . ." The pamphlet recommends that every man "have constantly about him a Lime" with which to allay the itching of "Musquetoe" bites and prevent scratching which commonly "produces Sores." "The Men are to be cautioned against lying on the Ground whenever it can be avoided, as it will fill them with Chiagoes and other Insects; and, if damp, will give them the Ague and Fever."[18]

Hospitals

When England took over East Florida, at St. Augustine there was a Spanish hospital on the plaza in the center of town. However, judging from the account of Dr. Catherwood, this was poorly equipped and not adequate for the number of sick. He states: ". . . The Beds were obliged to be made on a Terrass Floor, & all the precautions I could use was to have branches of Spruce Trees and Palmetto leaves laid under them, with the latter of which Palliasses were filled. and as it was a wet Fall and the Houses in which the Sick were lodged not water tight, the Bedding was so often destroyed that there was

scarce one month, I was not obliged to supply them with some parts thereof, particularly sheets."[4] In this account he lists hospital supplies he issued at various times: "Blankets, Sheets, Coverlets, Palliasses, Bolster Cases, Pillow Cases, Tin Kettles, Tin Pots (quarts and pints), Hammocks, Close Stool Pans, Bed Pans, Urinals, Lamps, and Hammock Ropes."

In the spring of 1770 the hospital was moved to the Indian Church, ". . . which is a more spacious and airy Building than the former (Spanish hospital in the heart of town), and is situated about a Quarter of a Mile from the Town."[19] This location was north of St. Augustine by the hornwork. Enclosed with Lieutenant Colonel Maxwell's letter to General Thomas Gage was a letter from Dr. Catherwood to Gage stating: ". . . if Bedsteads are not procured, the beding now in store will soon be Distroyd . . . fifty single bedsteads will be sufficient & when those are had, two Necessary Houses Built, and Wells sunk, it will be a Very compleat Hospital for the number it can contain. And its situation Extremely Healthy . . ." Gage replied he hoped "a less number of bedsteads would be sufficient" and instead of two wells as Catherwood requested, one good well should be sufficient.

The military continued to look with a jaundiced eye upon the expenditures of the hospital. We find Catherwood complaining to the War Office in February, 1777, "I even can't be allowed by the Garrison, a Spade a Shovell, or Rake to keep the Hospital properly clean."[20] Finally, in January, 1782, Governor Tonyn received instructions to abolish the General Hospital, "and that the sick should be attended by the Regimental Surgeons, receiving such assistance from the Garrison Hospital Mates & Mr. Catherwood, as He may find necessary."[21] Apparently the hospital census had dropped to a level that made continued operation of the hospital uneconomical. Thereafter, the Indian Church became a powder magazine; the Spanish hospital on the plaza had been converted to a jail and courthouse some ten years prior.

There is a brief mention of a Naval Hospital at St. Augustine to which a Dr. Thomas Cobham, formerly a prominent "practitioner in physics" in Wilmington, N.C., was assigned and which was removed to New Providence with the evacuation of 1783. Perhaps this was aboard a ship in the harbour.[2]

The hospital situation in West Florida was worse, if anything. When the British garrison took over from the French at Mobile the inventory of the hospital showed: "sixteen small distaff Bedsteads," "13 Spanish Hair Mattresses, Cloth covered," "Two large two-leaved Cypress cupboards, 8 feet high and 4½ feet wide, with lock and key, one sideboard ditto," "21 cloth bed sheets, half-worn," "21 old Spanish blankets," and 12 "Berts de Toile."[9]

These facilities proved inadequate during the sickly season for the following fall a private house was purchased as an auxiliary military hospital. At this time an observer noted, "the stench which issues from the barracks & hospitall is sufficient to knock a man down."[8]

At Pensacola the conditions were comparable. In a plan of the garrison "San Miguel de Panzacola," (September 2, 1763) the hospital is described as built with clay walls and a bark roof, "having two rooms for the sick, a medium room for the pharmacy and doctor's quarters, and a small room for clothing, and another used as kitchen."[22] The post engineer in a report of October, 1764, noted, "The Hospital is in the same bad condition no Chimney, wants to be Floor'd and to have Window Frames Sashes & ca . . ."[9] Not only were adequate physical facilities wanting but supplies and personnel were needed. Surgeon Samuel Fontenelle writing to a friend in England about the conditions at Pensacola in the summer of 1765 states, ". . . there is no regulation or provision made here for the Sick and that there is particularly wanting a Nurse to attend them, Firing and Candle for the Hospital . . ."[23]

In the fall of 1765, Governor George Johnstone built a temporary hospital at Pensacola which served until the arrival of General Haldimand in March, 1767. As part of his energetic program to improve the health of the garrison and the people of Pensacola Haldimand began construction of a new hospital in May, 1767, and it was roofed and ready for use in one month. Three years later Haldimand appointed "a carrefull Woman" to attend the sick at Pensacola.[8]

The problems of getting medicines for the sick of West Florida are vividly set forth in a memorial by Lorimer: "But the Sickly Season in this Country commences in June, and ends about the beginning of November; and our London Fleet sails about March or April, and generally returns about December or January. It is impracticable to send for any Invoice of Medicines by this Fleet, which will be exactly suitable for the next ensuing Year, when the Sickly Season of the Year then present is not yet begun. We are obliged therefore to guess at

the Medicines &c which may be wanted for almost two years to come; and if during that time we fall short of any Article there is no Person on the present Establishment, who is empowered to supply that, or any other Necessary for the sick, except at his own risque or expense. I am therefore considerable out of Pocket at this very time; by procuring the Necessary Article of Wine for the Detachment at Manchac, and Peruvian Bark for that and the other Detachments, which I was obliged to purchase at Jamaica New Orleans and Mobile &c . . . By some accident or other it has also happened oftener than once, that some Years we have had **no** Medicines or stores sent from England."[9]

It seems likely that the military hospitals were not available to the sick civilians. Thus in November, 1766, the council and assembly of West Florida petitioned the Right Honorable the Lords Commissioners of Trade and Plantations: "It is needless to remark to your Lordships . . . that there are so many Difficulties in the first clearing of a Country, and so many Diseases incident to such Labour, as well as to the changes of Climate, that the first Settlers have in general proved a Sacrifice to the prosperity of their Successors . . ." They go on to ask for the construction of, "Hospitals for the sick Inhabitants at Mobile and Pensacola, "and for L 600 per year for the "Maintainence of the Poor and distressed . . ."[9]

Physicians and Surgeons

In the documents related to Florida's British period there appear the names of about seventy physicians, surgeons or surgeon's mates.[24] Many of them were attached to the military forces but some appear in other roles such as: private practitioners, civil officials, land grantees, naturalists, Loyalist refugees, and three as political prisoners.

The most outstanding physician of British Florida was the King's physician at Pensacola, Dr. John Lorimer (1732/33-1795.)[12] Lorimer entered the British Army as a surgeon's mate during the Seven Years War. In 1764 he received his M.D. degree at St. Andrews. In March, 1765, he was appointed by King George III, ". . . to be Surgeon to the Hospitals for the Service of our Forces at Pensacola Etc. in Our Province of West Florida in America . . ."[9] He arrived at Pensacola in August, 1765, and his services were in demand from the moment he set foot ashore. Pensacola was at that time struggling with an epidemic of the putrid bilious fever and flux, and these were soon followed by the Jail or Hospital fever. Indeed, within the first month of his arrival the 31st Regiment, with whom he had sailed, had lost four officers, five of the six officers' wives and nearly one hundred men.

During the first several years of Lorimer's service in West Florida he was kept busy fighting disease and attempting to improve the health facilities there. However, he also served in the assembly representing Campbelltown, carried out observations on the weather, assisted cartographers (Thomas Hutchins, George Gauld and Bernard Romans) in mapping the area, and studied local medicinal plants and the "chalybeat water" of a spring near Pensacola. In recognition of these scientific endeavors he was elected a member of the American Society (a forerunner of the American Philosophical Society) in April, 1769, and was appointed deputy to the King's surveyor and auditor-general of the King's revenues. In 1776, when Bernard Romans, the Provincial Botanist, defected to the rebellious colonies, Lorimer was recommended to this position by the governor. His duty as a collector of "rare and useful productions in Physick and Botany" was to be rewarded by an annual stipend of L 50.

When Fort George at Pensacola fell to Galvez on May 8, 1781, Lorimer was among those made prisoner. He was allowed to go to New York where he served as Inspector of Military Hospitals during the winter of 1782-1783. Soon thereafter he returned to England where he continued his studies on the earth's magnetism, a subject which had interested him for more than twenty years. In 1795

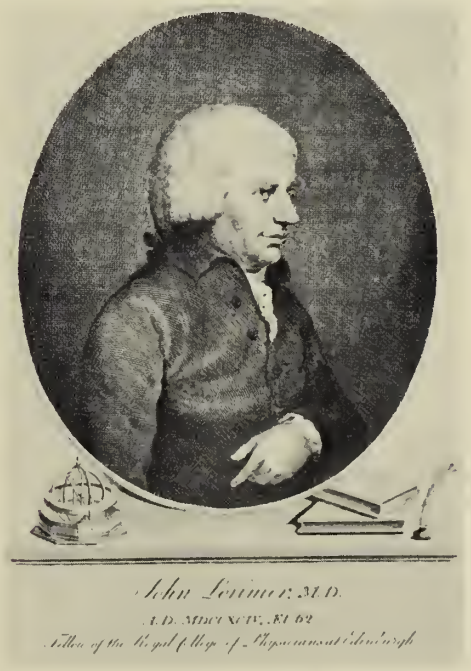


Fig. 4.—John Lorimer, M.D. (Courtesy of the Library of Congress).

he published a treatise on this subject: **A Concise Essay on Magnetism; with an account of the declination of the Magnetic Needle.** He died in London in July of that year; his obituary notes that he was a member of the Royal College of Physicians, Edinburgh.[12]

The King's physician in East Florida, Dr. Robert Catherwood, appears to have been less of a scholar and more of an opportunist. Catherwood was appointed, "Surgeon to the Hospital of Our Forces in the Province of East Florida in America," on February 27, 1764.[25] He had served with the Earl of Albemarle on the expedition to Cuba. His appointment seems to have been from half pay status and his annual salary was L 182.10.

Upon his arrival in St. Augustine in August, 1764, disease was not a great problem but the high cost of living was. In a letter appealing for the payment of certain contingency funds, Catherwood states: "On our first arrival in St. Augustine no Lodgings being provided for us we were obliged to Lodge ourselves at a very high Rent—I—myself was obliged to give for the only house I could hire forty pound a year Rent . . . We were allowed Lodging Money for some small time but for upwards of three years not one shilling of allowance, and our only hopes of redress is from your Excellency . . ."[4]

Soon after his arrival he was appointed a member of the council of East Florida. He continued in this position until his temporary suspension and subsequent resignation in the winter of 1783. During the governorship of the controversial Patrick Tonyn, Catherwood consistently sided with the governor which aroused the ire of Andrew Turnbull, secretary and clerk of the council, and a bitter enemy of Tonyn. When Turnbull was suspended by Tonyn, he lashed back with a blistering letter of defense which included an attack on Catherwood. He stated that the King's physician was "a bad apothecary who rose to be a worse surgeon with a proverbial disregard of the truth."[26] This suggests that Catherwood entered the medical profession by way of apprenticeship rather than the university route as had Turnbull. Catherwood held two other offices in the civil government: Assistant Justice of the Courts of Common Law and Judge of the Court of Vice Admiralty, both for the period 1776 to January, 1783.

As early as December, 1780, there is an implication that Catherwood was using his office as provincial surgeon to reward himself improperly. In a letter from Mr. Adair of the British War Office to Catherwood, December 26, 1780, Adair reproves Catherwood: "I have compared your monthly ex-



Fig. 5.—A Perspective View of Pensacola 1747. (Courtesy of The State Photographic Archives, Tallahassee).

pences with your Returns of the Sick, & in my humble Opinion the real Diseases bear no proportion to the Expences. The Quantity of Wine is great but the method of issuing it is hitherto unpractised in any Hospital. You serve it out by dozens, & charge it at the rate of four Shillings per Bottle for the most part, & none less than 3^{s} . 6^{d}. I find by your Letters that You purchase a large Quantity of Medicines, & charge them in your Accounts at the prices they are usually sold for by the Apothecaries in East Florida. Be Assured the Secretary at War will never suffer any Officer belonging to the Hospital to traffic in Medicines or Stores."[17]

However, it was his performance as Judge of the Court of Vice Admiralty rather than his implied embezzling of the hospital funds which brought about his trial, temporary suspension from all civil offices in January, 1783, and his ultimate resignation and departure from the province. The charges were that, "said Robt. Catherwood . . . hath asked, demanded and received divers large sums of money for and toward the Condemnation of various prizes brought into this province and libelled for condemnation in the said Court, and over and above the fees established . . ," and that, ". . . the said Judge hath publicly and notoriously declared in the said Court of the Admiralty that he was determined to receive such extraordinary fees and would not condemn any prize . . . without receiving such fee—under the denomination of an indulgent fee." The board of inquiry found him innocent of bribery but at the same time were of the opinion that Catherwood's actions had been, ". . . not only injurious to the subject and unbecoming the character of a Judge, but are mistakes, indiscretions and misdemeanors not to be justified."[27] The board recommended his suspension but apparently through the intercession of his friend, Governor Tonyn, "Means were used, and an opportunity afforded him of resigning these Offices, rather than be exposed to the unavoidable opprobrium of a suspension."[28]

In the **East Florida Gazette** for February 22, to March 1, 1783, there appears an advertisement signed "Robert Catherwood, Surgeon," which states: "All Persons having demands against the subscriber, on either his private account or that of his Majesty's Hospital, under his direction, are desired to bring in the same and receive payment, and requests those who are indebted to him, by bond, note, book account or otherwise, to discharge the same." It goes on to offer for sale "some valuable TRACTS of LAND" owned by Catherwood. In all he owned some 1600 acres which included a stone house on George Street in St. Augustine.[29,30] Presumably soon thereafter Catherwood left the province and diligent efforts have thus far failed to reveal information about his subsequent life.

Some of the military surgeons engaged in private practice on the side and possibly others upon release from the military. Catherwood, for example, in his plea for the release of certain contingency funds for the hospital, claims he had, "often supplied, not only the Regimental Surgeons, but the poor and needy, with those Medicines I bought for my private practice . . ."[4] One Loyalist refugee physician from Charleston, S.C., Hugh Rose, settled at St. Johns Bluff in January, 1783, and built a practice in which he "cleared above 200 Guineas" in eight months. In a plea for compensation from the Crown he averred that his income was "visably increasing" when he was forced to depart with the arrival of the Spanish.[2]

Among the several physicians who held important civil offices perhaps the most notable was John Moultrie, Jr. Moultrie, the first American medical graduate of Edinburgh and a practicing physician in Charleston before coming to Florida, served as Lieutenant Governor (1764-1771), Governor (1771-1774), and again as Lieutenant Governor (1774-1783) of East Florida. His land grants totalled 15,000 acres and his estate, Bella Vista, four miles south of St. Augustine was the show place of of the province.[31] Another notable physician in civil office was Andrew Turnbull whom we have previously mentioned as Secretary and Clerk of the council of East Florida from 1767 to 1785 with an interruption.

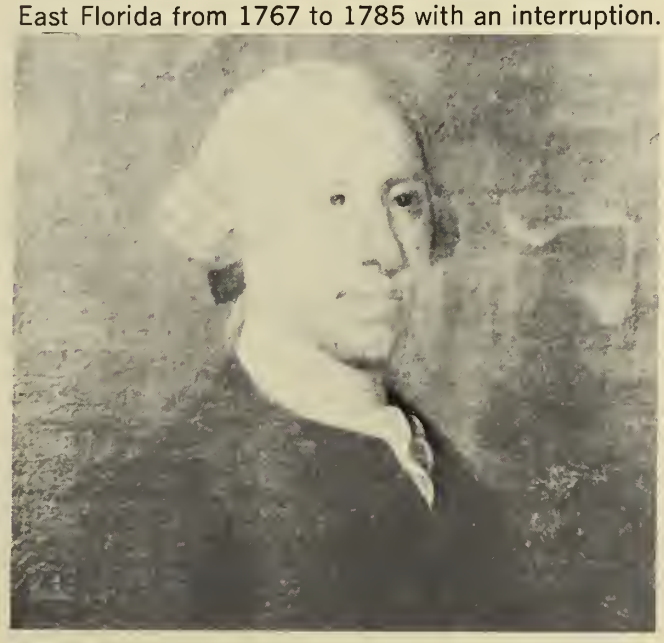


Fig. 6.—John Moultrie Jr., M.D.—1729-1798 (Courtesy of The Waring Historical Library, Charleston, S.C.)

Although placed under arrest by Tonyn, Turnbull escaped to England and in 1782 went to Charleston, S.C. where he engaged in private practice until his death in 1792. Although he was sixty-three years of age when he arrived in Charleston, it is said that very soon he "had nearly as much practice as any three of his profession."[32] Still a third important civil officer who was a physician is David Yeats, Deputy Secretary and Clerk of the council of East Florida from October, 1764, until the take over by Spain. Yeats apparently first came to Florida as Surgeon's Mate to the 9th Regiment.[33]

In still other ways physicians contributed to the British Floridas. We are indebted to two physician-naturalists, William Stork and John Bartram, for descriptive journals of Florida. During his visit to Florida in the winter of 1765-1766, Bartram became ill and he tells us: ". . . when at Augustine with fever and jaundice, I traveled both by water and land around the town for many miles, and to Picolata to the congress, although so weak during the meeting of governor and Indians in the pavilion, was forced to sit or lie down upon the ground close by its side that I might observe what passed."[34]

Florida's first newspaper, **The East Florida Gazette,** was published by a physician refugee from Charleston, William Charles Wells. Wells brought to St. Augustine a printing press which had belonged to his brother, John Wells, who was then a refugee in England. With the aid of an artisan he assembled the press and began printing a weekly newspaper in his brother's name.[35] This paper was published from late January, 1783, until Wells' departure from the province in May, 1784. Wells returned to London and engaged in a successful medical practice until his death in 1817. He is best known to students of medical history for his early description of the cardiac symptoms of rheumatic fever. However, he made several other original and important scientific observations including a concept of evolution many years before Darwin.

Three physicians were political prisoners in St. Augustine because of their outspoken rebel sympathies.[36] One of these, Nobel Wimberly Jones, was a founder and the first president of the Georgia Medical Society. More famous was David Ramsey, a prominent surgeon of Charleston. He served in various civil positions in South Carolina, in the Continental Congress, and as Surgeon of the Ancient Battalion of Artillery in battles against the British. After the revolution he returned to Charleston and subsequently served in the United States Congress, presiding over it in John Hancock's absence during the year 1786. Finally, he is remembered as the author of a two volume history of the American Revolution published in 1789.

The Summing Up

In this bicentennial year it is a popular pastime to re-examine the less sophisticated life of two hundred years ago and react with amusement, amazement and disbelief. We congratulate ourselves that we do not have to endure the monotonous, insipid and often inadequate food; the uncomfortable and infrequently laundered clothing; the primitive sanitary facilities; and the cramped, dingy, uncomfortable and often malodorous living quarters. We physicians are appalled at such practices as giving pukes and purges to already dehydrated patients, administering near-exsanguinating phlebotomies to the critically ill, and inserting foreign bodies (setons) into wounds to call forth "laudable pus."

Yet each period of history must be judged in light of the knowledge and problems of the day. Thus we must consider the less advanced state of medical knowledge two centuries ago, the inferior training of most of the physicians and surgeons of the British Floridas, the mechanical difficulties of the long supply lines which brought the food, clothing and drugs, and the often parsimonious support of a mother country spread too thin and engaged in war. Considering such factors the proper question is: Was medical care in the British Floridas on a par with that in similar contemporary areas? From the bits and dribbles of medical information available it seems likely the above question should be answered affirmatively.

References

1. Tebeau, Charlton W.: A History of Florida, Coral Gables, University of Miami Press, 1971, p. 74.
2. Siebert, Wilbur Henry: Loyalists in East Florida 1774-1785, Two Volumes, The Most Important Documents Pertaining Thereto Edited With An Accompanying Narrative, Deland, Florida State Historical Society, 1929.
3. Schoepf, Johann David: Travels in the Confederation (1783-1784), Translated from the German by Alfred J. Morrison, Philadelphia, William J. Campbell, 1911, p. 250.
4. An account and explanation of Doctor Catherwood of expenditures and issues of hospital bedding and stores from August, 1764, to April 20, 1774. In Great Britain, Public Record Office, War Office Papers ½, (Hereinafter cited as WO).
5. Corse, Carita Doggett: Dr. Andrew Turnbull and the New Smyrna Colony of Florida, Volusia County Historical Commission, Great Outdoors Publishing Co., 1919. (Revised Ed. 1967), p. 45.
6. Panagopoulos, E. P.: New Smyrna, An Eighteenth Century Greek Odyssey, Gainesville, University of Florida Press, 1966, p. 81.
7. Turnbull to Germain, Dec. 8, 1777, Sackville Manuscripts, America, 1755-1777, No. 100. William L. Clements Library, Ann Arbor, Michigan.
8. Rea, Robert R.: "Graveyard for Britons," West Florida, 1763-1781, Florida Historical Quarterly XLVII: 345-364, April, 1969.
9. Harrell, Laura D. S.: Colonial Medical Practice in British West Florida, 1763-1781, Bull. Hist. of Medicine 41: 539-558, November-December, 1967.
10. Eighteenth century disease terminology cannot always be equated with our current terminology and no detailed descrip-

tion of the diseases encountered in British Florida has come down to us. Therefore often we cannot identity the illnesses of that day. However, the following comments are offered as a rough guide to the reader. Intermittent fevers or agues were identified by temperature spikes interspaced with afebrile periods of fixed length. These were divided into tertian, quartan and quotidian according to the length of the afebrile interval. Today we call these malaria, a term first used in 1711, but not generally adopted for more than a century. A remitting fever was one which varied in intensity but never completely disappeared during the illness. The qualifying word "putrid" meant severe and the word "bilious" implied an abnormality of the bile in the tradition of the doctrine of the four humors. Thus bilious remitting fever and putrid bilious fever were terms usually signifying yellow fever, a term introduced in 1750. Perhaps at times putrid bilious fever signified typhoid fever. The fluxes were the various forms of diarrhea. Dropsies were any form of abnormal accumulations of fluid in the body or one of its organs. The Jail or Hospital fever was probably our present-day murine typhus. Cachexies were situations in which the patient seemed to waste away without any identifiable cause. This term covered many disorders such as: occult neoplasm, the various granulomatous diseases, collagen disorders, metabolic disorders, uremia, etc.

11. Pringle, Sir John: Observations on the Diseases of the Army, Seventh Edition, London, 1775.
12. Rea, Robert R. and Holmes, Jack D. L.: Dr. John Lorimer and the Natural Sciences in British West Florida, Southern Humanities Review IV: 363-372, 1970.
13. A "generous wine" was a wine (often sherry, Madeira or port) which was fortified by adding brandy to raise the "proof."
14. Quincy's Lexicon Physicio-Medicum Improved or A Dictionary of the Terms Employed in Medicine, Etc., from the 11th London Edition, New York, T. & J. Swords, 1802, p. 424.
15. Mustard and sauerkraut were used as scurvy preventatives; the value of lemon and lime juice had been proved by Lind in 1753, but his findings were not generally accepted until forty years later.
16. Merritt, Webster: West Florida, Three Centuries under Four Flags, Conquest and Disease, J. Fla. Med. Assn. 39: 749-765, April, 1953.
17. Adair to Catherwood, Dec. 26, 1780, WO 4/275.
18. Regulations For the Use of His Majesty's Troops Upon Their Arrival in the West Indies, No. II, War Office, Oct. 10, 1775.
19. Maxwell to Gage, June 2, 1770, Lieutenant General Thomas Gage Papers, William L. Clements Library, Ann Arbor, Mich. (Hereinafter cited as GP)
20. Catherwood to Adair, Feb. 25, 1777, WO 4/273.
21. Jenkinson to Tonyn, Jan. 30, 1782, WO 4/275.
22. Rush, N. Orwin: Spain's Final Triumph Over Great Britain in the Gulf of Mexico, The Battle of Pensacola — March 9 to May 8, 1781, Florida State University Studies, No. 48, Tallahassee, Florida State University, 1966, p. 138.
23. Fontenelle to Williamson, Sept. 1, 1765. The Francis A. Countway Library of Medicine, Boston, Mass.
24. In eighteenth century England there were two paths open to a man who wanted to become a physician or surgeon: attendance at a university, a path available only to the sons of the wealthy and commonly leading to a degree of doctor of medicine, and the more commonly traveled path, apprenticeship to a barber surgeon or apothecary. Almost all of the British naval surgeons of that period had begun their careers by becoming apprentices for a few months, at ages sixteen to eighteen then taking the appropriate examination given by the navy examining board. Having successfully passed this, they paid a fee of one guinea for a warrant as a surgeon's mate or three guineas for a warrant as surgeon. After serving more than three years as a surgeon's mate, a man might enter civilian life as a practitioner of surgery without further study, examination or fee. In England he would not be allowed to call himself a physician or use the title "Doctor," but in the colonies it is likely the custom was less stringent.
25. Roster of Officers in the West Indies and Floridas, WO 25/30.
26. Mowat, Charles Loch: East Florida as a British Province 1763-1784, Floridiana Facsimile and Reprint Series, Gainesville, University of Florida Press, 1964, p. 99.
27. Transcript of the trial of Robert Catherwood, Jan. 2, 1783 to Jan. 23, 1783, in Great Britain, Public Record Office, CO 5/547, folios 24-65.
28. Tonyn to Townshend, Feb. 3, 1783, CO 5/547.
29. Spanish Land Grants in Florida, Confirmed Claims, Tallahassee Records Survey, 1941, Vol. III, F 41 (8) (Claims of Jesse Fish)
30. In 1763 this house was owned by Charles DeLap, Justice of the Peace, from whom Catherwood bought it. The house still stands at 214 St. George Street and is currently owned by Mr. James S. Lindsley. (Personal communication from Mr. Luis Rafael Arana, St. Augustine.)
31. Townsend, Eleanor Winthrop: John Moultrie, Junior, M.D. 1729-1798. Ann. Med. History, Third Series, II: 98-109, 1940.
32. Waring, Joseph Ior: A History of Medicine in South Carolina, 1670-1825, Columbia, S.C., The South Carolina Medical Association, 1964, p. 322.
33. Gage to Taylor, Nov. 16, 1765, GP.
34. Cruickshank, Helen Gore, Editor: John and William Bartram's America, New York, The Devin-Adair Company, 1957, p. 90.
35. Wells, William Charles: Two Essays: One Upon Single Vision With Two Eyes; The Other on Dew . . . With a Memoir Of His Life Written by Himself, London, Printed for Archibald Constable and Co., 1818, p. xxi.
36. Manucy, A. and Johnson, A.: Castle St. Mark and the Patriots of the Revolution, Fla. Hist. Quart. XXI: 3-24, 1942, p. 16.

Dr. Straight, 550 Brickell Avenue, Miami 33131.

DROPSY

Recipe for dropsy: 200 grains cream tartar, 200 grains salt peter, 200 Squills, 200 Snake root. Put in 2 quarts water and boil down to 1 quart and put it in 1 quart whiskey. Dose: wine glass full three times a day before eating. If the water passes too free reduce the dose.

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Edward Jelks, M.D.
A Biography of Achievement

Linda C. Moseley

"All men are created equal, but some are more equal than others."

This familiar truism brings to mind different things for different people. Some think of the silver spoon, or material blessings; others may identify tangible advantages of time, situation, or circumstance which favor certain individuals. But what really makes a man "more equal?" Rather than material gifts or fortunate surroundings, we know that in the long run it is the intangible qualities — attributes of character and spirit — which enable a person to create and to lead a life that makes a lasting contribution and a wide circle of influence for good. Such qualities as competence, devotion, self-discipline and vision can indeed make a man more equal.

Those who know him well, both personally and professionally, and those who know him only by reputation, have long recognized these qualities as synonymous with the name of Edward Jelks, M.D., the Florida Medical Association's 62nd President. Christened Edward Coates Jelks, he later relinquished his middle name to a younger brother, and became simply Edward Jelks. Often shortened further to Ed, by himself and others, the name was sufficient to his needs, and became one to be reckoned with throughout half a century of medicine in Florida and the Southeast.

Early Years

Born in Hawkinsville, Georgia, June 9, 1888, Edward Jelks moved forty miles north to Macon with his parents and brothers in 1895. The Jelks family was originally from Wales, and this branch had come to Georgia from the Carolinas. Two great uncles were doctors in Georgia; Nat Jelks practiced in Hawkinsville and Edwin Jelks in Quitman. His father, Exum Nathaniel Jelks, had gone north to the Eastman Business School and planned business interests in Macon, including a brickyard. His mother, the former Bessie Coates, was already the mother of three boys—Edward, Jim, and Oliver—and had lost another son in infancy.

In 1897, Bessie Jelks died of complications and infection following the birth of her fifth son, Howard Coates Jelks. The ensuing year was a painful and difficult one for young Edward, who suffered agonies of grief, anxiety and depression. He had trouble with school, and vividly remembers disgrace and punishment resulting from his inability to work or respond in any way to the teacher's assignments. What the final effect of this loss might have been is fortunately not known, for soon Mr. Jelks introduced the boys to their new mother, Attie Ursula Moore. Miss Moore was a charming young woman ten years his junior, a graduate of the New England Conservatory of Music, an accomplished pianist, violinist, and organist. She and Nathaniel Jelks had taught Sunday school together, and this mutual interest and friendship lead easily to love and marriage in 1898. She "knew just how to get along with children," interesting them in games and music, and "just loving them." She, in time, presented Mr. Jelks and the brothers with three beautiful, golden-haired sisters—Charlotte, Ruth and Marie. In Dr. Jelk's own words, "I always loved the girls because I



Fig. 1.—Exum Nathaniel Jelks

Mrs. Moseley is the wife of Thad Moseley, M.D. of Jacksonville.



Fig. 2.—Bessie Coates Jelks

loved their mother so much. I worshiped her." One of her oldest stepson's fondest memories is of how she taught him to play the cello, his brother, Jim, the clarinet, and Oliver the violin. She accompanied them on the piano. They played on Sundays and special occasions at the Baptist Church in Macon, and even gave concerts at Wesleyan College! Howard was too young to be in the family orchestra but the three older boys kept their interest in music all of their lives; Oliver became a very good violinist. Between Mrs. Jelks' teaching of music and Mr. Jelks' passion for reading aloud to his brood from Shakespeare and the Bible, the young Jelks were exposed to cultural advantages that would be the envy of any child, even today. Certainly their imaginations were stimulated, and they had a warm and devoted family atmosphere.

Perhaps the most profound influence on young Edward, from the standpoint of his future life and profession, was his admiration for Mrs. Jelks' father, Dr. Kingman Porter Moore. Dr. Moore had served as an orderly in the Civil War and had gone on to a lifetime in medicine as a country doctor. Although Macon was a good sized town, Dr. Moore's practice ranged the countryside. He traveled by buggy, often accompanied by young Edward. Dr. Moore built a small private hospital in Macon, and admitted those patients who could best be cared for there. His wife assisted, often cooking for the patients. Dr. Moore had a warm affection for the boy, and Edward's lifetime preoccupation with medicine as a healing art and with people as patients was born and nurtured. Dr. Moore's life and work were an inspiration; his son, Johnson Moore, became a physician also, following in his father's footsteps. Dr. Jelks can recount many anecdotes from his experiences making rounds with the good Dr. Moore.

Education

Education had always been important to the community of Macon, then a growing town of 30,000 with two well known colleges. So Edward was fortunate in that, unlike many of his generation, he was able to attend good public schools. He walked to school, accompanied by his brothers as they in turn became old enough to go. Though the trip to elementary school was closer, the walk to and from high school was four miles daily. Edward was a diligent student and well-prepared to move on to Mercer University, a small Baptist-affiliated school in Macon. In fact, he was so well grounded in ancient history by an inspiring high school teacher, that the Dean at Mercer asked him to teach a seminar in ancient history to theological students. Since the students paid a fee of $10 each, and he had 15 to 20 students in the seminar, he was wealthy beyond his wildest dreams! With this financial windfall he paid, among other things, his fraternity fees to Phi Delta Theta, of which he was president his senior year at Mercer.



Fig. 3.—Attie Moore Jelks



Fig. 4.—The Jelks Brothers: (from left) Oliver, Edward, Howard and Jim. Edward was 11 or 12 years of age.

Since Edward had known for years that he wished to be a doctor, there was no decision to be made at graduation. His application to Johns Hopkins Medical School was accepted; he left for Baltimore and the intensified pursuit of his medical education. Johns Hopkins, long one of the foremost medical schools in the country, offered much to the dedicated student. It is one measure of the young man at this time that the most memorable experience of his training years—other than his medical and hospital experiences—was the Sunday night service for students and interns. Every Sunday evening there was a worship and fellowship service; prominent laymen, ministers and physicians were invited to address the students and young doctors. He was chairman of the committee which arranged these evenings, and gained much inspiration from them. He can still quote from some of the talks! Edward was also president of his medical fraternity, Phi Chi. He received his M.D. degree in 1913, one of a class of 72.

Edward Jelks stayed on at Johns Hopkins Hospital as a house officer, taking a general residency in 1913 and 1914, and was singled out by Dr. William S. Halstead for the residency in surgery. However, Nathaniel Jelks had suffered severe financial reverses when a Macon bank in which he had substantial interest failed. Young Dr. Jelks felt that he could not afford further training, that he should instead contribute to the family finances. He regretfully declined the rare privilege of a residency with the legendary Dr. Halstead, and worked that year as an assistant in the radiology department and as an instructor in laryngology.

Beginning Practice

Meanwhile, a situation had developed in Jacksonville, Florida, which was to become a major factor in the young man's life and career. Dr. Carey P. Rogers, a Johns Hopkins graduate, was the first physician in Florida to limit his practice to surgery. He had been practicing in Jacksonville with a group of six doctors at the DeSoto Sanitarium (later purchased by the Catholic Diocese and continued as St. Vincent's Hospital) but this association had proved unsatisfactory for him. In 1911 he had established his own private facility, which he called the Rogers Hospital. Early in 1915 he was in Baltimore in search of an assistant for his practice and approached young Dr. Jelks with an offer to work for him. Jelks felt he needed to begin practicing and the idea of locating in Jacksonville appealed to him; Dr. Rogers' offer of $200 a month appeared munificent. He accepted, moved to Jacksonville in June 1915, was licensed to practice in Florida, and commenced work.

At Dr. Rogers' hospital, by then known as Riverside Hospital, Dr. Jelks practiced medicine and surgery, and his previous experience at Hopkins enabled the hospital to offer Jacksonville the first inpatient radiology service by a staff physician. He also administered anesthesia for the surgery performed at Riverside. The hospital had a fine small school of nursing in which he taught, as did the other doctors. Mindful of the reason he had passed up a residency to go into practice, from the first month he sent half his salary home to his father.

Marriage and the War Years

The years 1915-17 were eventful for the young physician. In addition to being busy with his practice, he made many friends. Living in rooms at a Mrs. Warfields's on Park Street, he came to know and work with young Dr. Harry A. Peyton, a surgeon

and urologist. Dr. Peyton's pretty cousin, Isabelle Peyton Welch, liked to come to Jacksonville to visit and shop. Her father, Dr. George E. Welch, practiced medicine in Putnam County and they lived in Palatka. She always looked up Cousin Harry and soon met his friend, the young surgeon from Macon. A Kentuckian transplanted to Florida, a Wellesley alumna, she was a feminine, mature and intelligent young lady—just the wife he had hoped to find. There was nothing dilatory about Ed Jelks when he knew what he wanted, and the feeling must have been shared by Belle Welch. When he volunteered to serve in the Army Medical Corps in 1917 on the outbreak of World War I, they decided not to postpone their wedding. Chaperoned by Belle's mother, they went to Chattanooga to await his orders. Also in Chattanooga with them were the Peytons, recently married, and another young couple, the Turner Z. Casons. Ed and Belle were married there and visited his family in Macon on their honeymoon! In two months he was overseas where he spent 18 months in France and England with the A.E.F. He was discharged with the rank of captain.

The war months, in addition to extensive medical and surgical experience, provided Drs. Jelks, Peyton and Cason with the opportunity to consider and plan what they wished to do afterward. They wanted to practice in Jacksonville and decided, upon receiving their discharges, to share an office, practicing more or less independently. In the spring of 1919, the three opened an office in downtown Jacksonville at 223 West Forsyth Street. They shared two desks and rode the streetcar to St. Luke's Hospital to see patients. They employed one nurse, Miss Sarah Spears, who was to play an important role in their careers.



Fig. 5.—Attie Moore Jelks, stepmother of Edward Jelks and Mrs. George E. Welch, mother of Mrs. Edward Jelks taken in 1915.

During the next year, purely on the strength of their character and prospects, they entered into an agreement with several other local physicians, among them Dr. H. Marshall Taylor and Dr. James V. Freeman, and built an office building downtown near the corner of Laura at 111 Adams Streets.



Fig. 6.—Dr. Kingman Porter Moore

Group Practice

Scarcely were they in their new location in 1920, when the event occurred that was the turning point in their lives. Dr. Rogers wished to leave Jacksonville and offered to sell Riverside Hospital to the three young doctors. With the help of the Barnett Bank, they found they could meet his asking price of $80,000. It was too much of a challenge to pass by. Dr. Jelks, especially, had a visionary idea of a clinic group, and had previously been to Mayo Clinic where he spent some time studying the organization and procedures. Dr. J. H. Hartman, who was working for Dr. Rogers, stayed on at Riverside Hospital as resident staff doctor for two more years. For a while the three new owners maintained two offices—downtown and at the hospital. Then they were able to divest themselves of their obligations

in the downtown building, and practiced solely at Riverside. Theirs became an experimental group practice, the first in Florida, one of the first in the Southeast, with very few precedent groups on which to model itself. The arrangement was based on mutual trust, friendship, and a willingness to work things out as they went along.

The three men paid all hospital expenses first and then drew modest, equal salaries. The hospital did not have a completely open staff because of its small size but qualified physicians in the community, in specialties not covered by the group, did bring patients there. Operating within this fairly simple framework, the group was able to innovate and pioneer in small but effective ways—always with the object of better care for the patients. They hired a business manager so they would not have to spend their professional time in this way. Miss Spears went away for special training, returned to operate the laboratories, and proved to be a genius at this job. They continued the school of nursing, in which they all instructed; they initiated medical and surgical residency training for young doctors, later approved by the specialty boards. The first board-approved residency in anesthesiology in Florida was at Riverside Hospital.

The three doctors spent two decades improving what they had inherited and building up the level of excellence of medical practice in Jacksonville and North Florida. They did increase their group by two men, Dr. Frank Slaughter and Dr. C. Webster Merritt, in the years immediately prior to World War II. but expansion of both the clinic group and the hospital capacity was to await the era of their successors. A third decade—the war and postwar years—was spent in running a wartime operation, in adding new men to the group, and in thinking and planning with them for changes that would have to be made in a growing community and an expanding profession.

Upon the retirement of the three founders, the responsibility would be passed to their young associates. The clinic group would be greatly enlarged; the hospital itself would be turned over to a board of trustees for management, and given to the community; a building program would enlarge the hospital and enable the staff to be completely open to qualified men in all specialties. Community recognition and 55 years of medical history have testified that Drs. Jelks, Peyton and Cason, in their individual and combined careers, made a singular contribution to medicine in the Southeast through this clinic and this hospital.

One unique aspect of Dr. Jelks' professional career during its earlier years deserves special mention. Picture the undeveloped state of Florida during the 1920s and even into the 1930s. Medicine in most areas was primitive and totally lacking in any facilities or specialization. But there were people in these remote areas, and country doctors. Often when surgery was needed, Dr. Jelks was called in by the family doctor to perform it. He did this routinely, traveling by train or any other conveyance available, going as far as Key West, working with the local physicians and the equipment at hand. Sometimes he would stop and perform surgery, perhaps at Cocoa, on the way to Miami; then stop on the way back to check on the patient and confer with the local doctors. By his own admission, his patients did well. As time passed, communities attracted their own surgeons and Dr. Jelks was able to curtail his traveling for operating purposes, but transportation improved and patients still came to him. He maintained a large out-of-town referred practice. Patients still travel today to Jacksonville doctors from as far away as Vero Beach, simply because of confidence and habits engendered by the circuit riding surgeon who unselfishly journeyed far to help people when to go to them was the only way.

Duval Medical Center

From the many achievements in his private practice, which would have been sufficient for most men, Edward Jelks moved out to serve his community, his profession and its organizations, his state and his country. He had a flair for teaching and a disposition that was effective in organizational work; these talents he employed in many and diverse ways, from the early 1920s into the decade of the 1970s.

Since 1922 he had been giving his time and skill at the Duval County Hospital on Jesse Street, and for more than forty years, Ed Jelks contributed unstintingly to the growth and development of this institution. First he was Chief of Orthopedics and Laryngology under Dr. John Elliott Boyd. In 1937, Dr. Jelks became Chief of the Surgical Service. This demanding volunteer role he filled until 1953 when he was succeeded by Dr. Kenneth A. Morris. He held grand rounds every Sunday, diagnostic clinic every Wednesday, and operated every Tuesday and sometimes more often. He began the surgical residency training program, AMA approved in 1938, where there had only been a rotating internship. His first resident was an outstanding young Hopkins gradu-

ate, Dr. George Morse, who went on to practice in Pensacola; his last was Dr. Clyde Collins, of Jacksonville, former Editor of the FMA Journal.

After Dr. Jelks' retirement as chief of surgery, he was appointed by Governor Dan MaCarty in 1956 to the Hospital Authority, the policy making and executive board for the hospital—by then called the Duval Medical Center—and served until December, 1963. Dr. Jelks believes that the contributions of DMC to medicine in Duval County have been very significant: an outstanding training program from which almost 200 doctors have remained to practice in Jacksonville and hundreds more have remained in Florida; the most modern radiological therapy in the community for many years; and the first psychiatric inpatient unit in the county. His close identification over the decades with this institution, which is now University Hospital of Jacksonville, means that these contributions are, in part, his contributions also. In recognition of his role in its development, the Duval Medical Center for many years called its annual affair for awarding of certificates to house officers the Edward Jelks Dinner.

Medical Organizations

Dr. Jelks was elected President of the Duval County Medical Society in 1929. (He says he was absent from the meeting!) With a talent for getting people to pull together, by inviting interesting speakers, and serving sandwiches and coffee, he was able to increase monthly attendance at meetings during the year from about 15 to 50. He enlisted the advice and support of older physicians, past presidents of the Society such as Dr. Boyd and Dr. Robert H. McGinnis. He also initiated a newsletter prior to each meeting and invited submission of items—the forerunner of the present Bulletin. More importantly, a greater feeling of pride and fellowship and interest in medical affairs ensued.

When Dr. Jelks came to Jacksonville in 1915, there were about 65,000 people and the Proceedings of the Florida Medical Association Annual Meeting in 1916 refer to the Duval County Medical Society as "burgeoning . . . with over 100 members." By 1930 when he had completed his term as President, the census showed 129,547 people and the roster of the Society had 152 members. Dr. Jelks went on to serve the Florida Medical Association as a delegate from Duval and his interest in the local Society never flagged. He remained interested and supportive of all subsequent administrations and many presidents of the Duval Society turned to him for inspiration and counsel.

Recognizing him as an outstanding surgeon, many organizations offered Dr. Jelks membership and sought his leadership throughout this period. He was a member of the Southern Medical Association and Counselor from Florida, President of the Florida East Coast Medical Society, and a member of the Southeastern Surgical Congress. He was a founding Fellow of the American College of Surgeons, President of the Southern Society of Clinical Surgeons, and a Fellow, Vice President and member of the Board of the prestigious Southern Surgical Association. He was also a founding member of the American Board of Surgery. In Jacksonville he was President in 1931-32 of the Jacksonville Historical Society, an outgrowth of his genuine interest in both his community and its history.

In the years between his early practice and the late 1930s, Dr. Jelks wrote many papers for various publications. Several of them, one on Dr. John Gorrie and one on Dr. Ephriam McDowell, for instance, reflect his sustained interest in medical history. During his years as chief of the surgical service at the Duval Medical Center, he collaborated with his house officers and residents on a number of papers, most of which were published under the names of the younger doctors.

The Florida Medical Association elected Edward Jelks its President in 1937. During this year of office, it was his special priority project to "take the Association to the county medical societies." Dr. Shaler Richardson, then secretary-treasurer, assisted him. At their own expense they visited and spoke to every county medical society in Florida. These visits resulted in the establishment of the District Meetings, which were vehicles for taking the officers and the business of the Association to the local communities. This practice continued until the late 1950s when it was replaced by the Conference for County Medical Society Presidents and Secretaries.

During Dr. Jelks' presidency, and under the legislative chairmanship of Dr. Julius C. Davis of Quincy, the Florida Medical Association had one of the most active legislative periods in its history up to that time. Medicine needed to be concerned with schools, health conditions, rural health services, migrant workers, and the state's responsibility for communicable disease problems. The Association worked closely with the legislature on tuberculosis control and the state sanitarium in Orlando officially opened on January 3, 1938 with the Association's encouragement and assistance.

At the Association's Annual Meeting in 1938, the Presidential Address was delivered by Dr. J.M.T.

Finney from Johns Hopkins, one of America's outstanding surgeons of the century. Dr. Finney had been Chief of the Surgical Section of the Medical Corps of the American Expeditionary Forces in World War I. Dr. Jelks' close friendship with him dated from these years.

Dr. Jelks' term as President was busy and productive but did not signal the end of his efforts on behalf of the Association. He continued to participate, heading the Committee on Medical Preparedness in 1941 and the War Preparations Committee during the war years. He served FMA as delegate to the American Medical Association. Upon retirement from active practice in 1953 he was designated public relations officer for the FMA Board of Governors. In this capacity he devoted several years until 1958, again at his own expense, to strengthening the organizational structure of the Association in its relationship with the component county societies—visiting each society, some frequently. Says W. Harold Parham, D.H.A., Executive Vice President of the Association, "This had a lasting influence and materially affected the strength of organized medicine in Florida, a strength still apparent today."



Fig. 7.—(from left) Allen N. Jelks Jr., M.D., nephew of Dr. Jelks and presently a practicing pediatrician in Sarasota; Howard Jelks Jr., nephew of Dr. Jelks and a practicing optometrist in Ft. Lauderdale; Oliver Jelks Sr.; Howard C. Jelks Sr. and Edward Jelks (Other brother, Jim, died in 1942).

Dr. Jelks's chairmanship of the FMA Building Committee in 1956 resulted in construction of the Association's executive offices at 735 Riverside Avenue in Jacksonville. He could recall 1923 when FMA was headquartered in an office in the Florida Title Building with Stewart G. Thompson, D.P.H., as Executive Director; this perspective gave him special pride and pleasure in the completion of the new building. Dr. Jelks also served as the first President of the Florida Medical Foundation from the year of its founding in 1956 until 1959. The Foundation was a pioneer effort and its development and ramifications since would make another whole story which space will not permit.

Blue Cross and Blue Shield

Another story, however, **must** be sketched: Edward Jelks' seminal role in the formation and development of Blue Cross and Blue Shield. Those for whom Blue Cross and Blue Shield have been household words for a lifetime cannot conceive of how visionary, even radical, was the concept of organized prepayment of medical care at its inception. The need was an outgrowth of the poverty of the depression years. The pioneers who undertook to provide a plan to enable every person to afford medical care were not only humanitarian and courageous, they had to be practical-minded and determined. It was not to be an easy task.

It is generally acknowledged that Circuit Court Judge Bayard Shields granted the charter to the Florida Hospital Service Corporation—later Blue Cross—substantially on the basis of his high opinion of the integrity of H. Plant Osborne, William E. Arnold, and Edward Jelks, who conferred with him on behalf of the charter. Ted Arnold, Administrator of St. Lukes Hospital, had a prepayment plan based on the Baylor, Texas Plan for his hospital and was convinced that prepayment could work on a statewide basis.

Early in 1944, Mr. Arnold enlisted Dr. Jelks to inform and gain support from the medical profession. He, Dr. Jelks and W. A. Nelles of Riverside Hospital stumped the state soliciting $25,000 in financial contributions from hospitals. Dr. Jelks and Dr. Leigh F. Robinson also led in soliciting $18,000 from Florida physicians to underwrite the Florida Medical Service Association, forerunner of Blue Shield, which Dr. Robinson served as first president. Dr. Jelks worked with other early leaders of the Blue Plans, shepherding the fledgling, floundering organizations through the shoals of the attorney general's office, the legislature, the Florida Insur-

ance Commission, through near financial disaster, and through the Florida Medical Association—where many of his friends and peers had grave doubts and voiced them. He was a subscriber to the charters of both Blue Cross and Blue Shield and a member of both original boards. He served Blue Cross on the first Executive Committee, as vice president, as assistant treasurer, as chairman of the Committee on Retirement Plans, and in 1966 as chairman of the Building Committee.

Dr. Jelks retired from the Blue Cross Board in January 1970 after 25 years of continuous service. Hilary Schroeder, former managing director of the Blue Plans, and recognized as the executive force behind their eventual success, said at that time: "Dr. Jelks, in 1944, was the most influential man in the FMA House of Delegates. A recent Past President, he laid his prestige and ability on the line for his conviction—that both hospitals and patients needed these plans—and he worked tirelessly for their success."

World War II Duties

During World War II and concurrent with work already alluded to—his private practice, the DMC Surgical Service, FMA responsibilities, and his founding efforts with Blue Cross and Blue Shield—this man of prodigious talent and capacity and professional conscience was discharging another extraordinary job—one which he admits was a tremendous source of pride. He was Procurement and Assignment Officer for Physicians for the State of Florida from 1941 to 1945. This meant that he had responsibility for approval or denial of deferments for the military service, and responsibility for making certain that all communities retained minimal medical coverage. The pressures involved when decisions were difficult, or when those going to war were men he knew personally, were heightened by difficult wartime travel conditions and the endless time required. Struggle with the Washington bureaucracy was alternately time-consuming and ludicrous. Relatively unrecognized and unsung, this job, however, was one which gave Dr. Jelks real satisfaction. He received a handsome citation from President Harry Truman and says "I'm as proud of it as of anything I've ever done."

Retirement Years

Dr. Jelks' parents had moved to Pompano Beach in the thirties where his father, a realtor, died in 1936. His three sisters, two of them educated at Tallahassee and further at the Universities of Chicago, Michigan, and Georgia for careers In teaching and social work, were by then living in Jacksonville. Oliver lived in Austin, Texas, Jim in Pompano, and Howard in Ft. Lauderdale. (Howard's son, Dr. Allen Nathaniel Jelks, is now a pediatrician in Sarasota.) When Mr. Jelks died, Mrs. Jelks came to Jacksonville to live with her daughters and be near Ed and Belle until her death in 1941. For almost the same ten years, the widowed Mrs. Welch lived with her daughter and son-in-law, Dr. Welch having died in 1934.

Upon his retirement from practice in 1953, Dr. Jelks is known to have expressed his intention to devote the remainder of his life to his wife Belle, to his colleagues through medicine in Florida, and to his teaching activities as long as he was needed. Again, according to Harold Parham, "He modestly felt that his entire professional fulfillment and any success that might be attributed to him had been accomplished through the love, support, and assistance of his family and his associates."

During the next fifteen years, until Mrs. Jelks' health began to fail in the late 1960s, she and Dr. Jelks enjoyed more companionship and time together in the home they had built near the St. Johns River in 1922 than they had enjoyed for 35 years. He had never failed to credit her for encouragement in his professional undertakings. They were child-



Fig. 8.—Dr. and Mrs. Edward Jelks in 1964.



Fig. 9.—After more than 25 years of service, Dr. Jelks retired on January 24, 1970 from the Blue Cross of Florida Board of Directors. He is standing by the oil portrait, presented to him by Mr. Frank J. Kelly, Chairman of the Blue Cross Board.

less, and Miss Belle was quite active herself in the Church of the Good Shepherd, in the Jacksonville Woman's Club, in the Garden Club, in the Colonial Dames, and the Junior League of Jacksonville. A doctor's daughter, she had understood and supported the demands of his profession; she was a strong, wise and dedicated wife for a committed physician. Dr. Jelks' devotion to his wife in her failing health has been the primary force shaping his life for the past several years.

One arena in which Dr. Jelks had possibly failed to see himself as having a further contribution to make was that of his immediate community of Jacksonville. It was apparently waiting to capture a share of his time and availability. Those who worked with him testify that during the 1960s and into the 1970s his contributions to Jacksonville community agencies have been distinguished—the distillation of years of medical, political, and human experience.

He served on the United Fund Board and Budget Committee, on the Community Planning Board, and for five years on the Committee on Aging. He continued on the visiting staff of the University Hospital of Jacksonville, attending medical rounds.

He was re-elected in 1969 to the Board of Directors of Riverside Hospital, after an absence of 16 years, to serve as an objective and experienced member. In 1972 he received the Riverside Hospital Merit Award, presented only twice to date, for his extraordinary contributions and, in the words of Finley Tucker, President of the Board, "for his brilliant and unequalled career as a physician and humanitarian . . . The good that a man does **does** live after him. . ."

Dr. Jelks was the first recipient of the Florida Medical Association's Certificate of Merit, a coveted honor originated in 1956. In attempting to summarize his life's work, it is helpful—it may even be sufficient—to quote from this award. It commends his "unswerving loyalty, his complete dedication, his prodigal expenditure of time and talent, at great personal sacrifices, in the interest of the Association and of organized medicine as a whole, and his innumerable contributions to the art, the science, and the socioeconomic progress of medicine in Florida and in the nation."

To write of such a career as Dr. Jelks' is to end with a feeling of disbelief that one man could truly achieve all the things recorded and live to see the results of his achievements. Medicine has been his profession, his vocation and his avocation. His has been a career that has moved, inspired, and cataloged accomplishments—representing a quantum leap for medicine in 20th century Florida.

▶ Mrs. Moseley, 1880 Edgewood Avenue South, Jacksonville 32205.

Notes on the History of Leprosy in Florida to 1921

Joy S. Richmond, M.L.S.

It is generally accepted that leprosy — today's Hansen's disease—did not exist in what is now the continental United States until after the New World was opened for exploration at the end of the 15th century. There has never been any evidence of the disease in the indigenous Indian tribes, nor did they later show a susceptibility to it as they did to other diseases introduced by the newcomers.

Leprosy entered the United States as an import, along with the languages, customs, and religious beliefs that were brought from older cultures. The importation of the disease into this country occurred in three successive ways: by European discoverers, explorers, and early settlers from countries where leprosy prevailed; by slaves brought over by the Europeans from areas in Africa where the disease is even today highly endemic; and by later waves of immigrants from parts of the world where leprosy had long existed.

For reasons still no more than speculative, leprosy has not flourished in the United States as it has elsewhere in the world, except in certain areas of Texas, Louisiana, California—and Florida. In these few areas, not only was the disease brought in by foreigners, but numbers of native-born persons also developed it.

The story of the importation of leprosy into each state is unique, and has to do with the state's role in the early history of the country. As for Florida, the disease possibly entered through all three routes that brought it into the United States as a whole. First, Florida was discovered, explored, and settled by Spaniards, in whose homeland leprosy existed in the coastal provinces. Second, the state had close proximity to the Caribbean slave markets. And third, over the years, immigrants have come to live in Florida from many parts of the world, particularly from Europe and from countries south of the United States where leprosy appeared early and thrived.

The presence of leprosy within the boundaries of the present-day United States has been noted in print only slightly longer than the nation has existed. Bernard Romans, a British surveyor, cartographer, and botanist, described the disease in 1775 in the provinces of East and West Florida, which extended from the Atlantic westward to the Mississippi River. In "A Concise Natural History of East and West Florida," published in 1775, he wrote, "The chronic diseases are dropsies, consumptions, hemorrhoidal and habitual fluxes, relaxed and bilious habits of body, ruptures, worm-fevers, and among blacks the leprosy, elephantiasis and body yaws. . . ."[1] And in the first known clinical description of the disease in the United States, he also wrote,

> The Leprosy so called, whether the same as was the cause of proscription to the unhappy patients under the Mosaic laws I shall not pretend to determine; certain it is, that it is a nauseous, loathsome and infectious disease . . . this appears first with the loss of beard and hair from the eyebrows, swelling of the lobes of the ears, the face begins to shine and brown protuberances appear thereon, the lips and nose swell to a monstrous size, the fingers and toes will in the end drop off, and the body becomes at last so ulcerated as to make the poor incurable patient really a miserable object of pity.[2]

Leprosy, the Problem

Another century was to pass before leprosy and its victims in the United States were to be recognized by American health officials as problems that required attention. During the last quarter of the 19th century, the whole Western world grew alarmed that a widespread epidemic of the disease, similar to that which reputedly swept over Europe during the Middle Ages, was on its way. One Dr. Pitkin was quoted in 1896 as saying that "there would be 'within the next ten years at least 250,000 to 500,000 lepers included among the inhabitants of the United States.' "[3] Although the leprosy bacillus, Mycobacterium leprae, had been discovered 23 years before, there was still neither cure nor vaccine nor medication of generally accepted value.* Thus, pronouncements such as Dr. Pitkin's about one of man's oldest, most dreaded diseases were frightening to consider.

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*Chaulmoogra oil was used at this time for treatment. Mangrove bark from Florida was also used at the Louisiana Leper Home both to relieve the accompanying nausea and, later, as a specific.

Alarming reports about the presence of leprosy in Florida began to appear early. In 1881 the New York Daily Tribune carried this unsigned letter:

> Sir: . . . Some three years ago while on the Island of Key West, Fla., I was surprised to find leprosy there in all its horror, and making bold to speak of the matter, I was immediately condemned for attempting to injure the commercial prosperity of the place. . . . I was stationed at Key West for six or seven years, and can confidently state that there are many cases of leprosy on that island, whole families being afflicted with it. . . . No provision is made for the unfortunates; they dwell surrounded by the masses, intermarrying and die. . . . This disease has been thoroughly and undeniably traced to the English possessions in the adjacent islands. . . . A selfish spirit prompts the leading people of that beautiful but poisonous island to disguise the real state of affairs existing there, and I would take but little comfort in smoking a genuine Key West cigar, knowing of the existence of these horrible facts. . . . Only government officials, like myself, know of these horrors, and strangers have been repeatedly lured there only to find a grave. . . .
>
> Milwaukee, Wis., June 24, 1881.[4]

The southernmost city of the United States, Key West, with its proximity to the Caribbean, was to remain the primary focus of leprosy in Florida for many years. Between 1880 and 1975, 129 Florida-born persons were diagnosed in the state as having leprosy, and 97 of these patients were born in Monroe County, with Key West as the core. Table 1 shows the numbers of reported cases by decades, regardless of place of birth, in Monroe County through 1968.[5] The actual number, especially between 1880 and 1920, was undoubtedly higher.

Through reports by various medical and diplomatic officials, there was a growing awareness in this country during the 1870s and 1880s of the prevalence of leprosy throughout the West Indies, and particularly in Cuba. Although the extent of leprosy in Key West was questioned, the fact that it existed was not; one quoted report put the figure at over 100 patients.*

Precipitated by the situation in both Havana and Key West, the first significant step to control leprosy in the United States was taken in 1889. At the meeting of the American Public Health Association in October, Dr. Benjamin Lee presented a paper titled "Do the Sanitary Interests of the United States Demand the Annexation of Cuba?"[6] He discussed the existence of leprosy in some of the Caribbean islands, but was most concerned about Cuba because it was the closest to Key West. He suggested that the Association pass two resolutions: (1) Urge the President of the United States to negotiate with

*A letter that appeared in the New York Medical Journal, January, 1889, contained this sentence: "Dr. Berger, of Tampa, Fla., who has made extensive personal investigations of leprosy in Key West, Cuba, and Nassau, as well as in this country, writes me that he is convinced that there are over a hundred cases in Key West alone, and that he has personally inspected thirty advanced cases in that island."[7]

Leprosy in Monroe County, Florida

1880-1968

Decade	Population	Cases reported	Incidence by year of report*	Recorded onset**	Incidence by year of onset*
1880-89		1		1	
1890-99	18,786	6	3.2	4	2.1
1900-09	18,006	3	1.7	2	1.1
1910-19	21,563	6	2.8	22	10.2
1920-29	19,550	34	17.4	19	9.7
1930-39	13,624	32	23.5	26	19.1
1940-49	14,078	24	17.0	14	9.9
1950-59	29,957	14	4.7	7	2.3
1960-68	47,921	5	1.0	2	0.4

*per 100,000 population per year

**not given in 28 cases

Spain for the amicable purchase of Cuba so that leprosy and other contagious diseases could be better controlled, and (2) Request the Supervising Surgeon General of the Marine Hospital Service, the chief of the State Board of Health of Florida, and quarantine commissioners of all ports having commerce with Cuba to show the same concern about leprosy as was already shown for yellow fever during its quarantine period, i.e., no alien with the disease would be allowed to enter the country.

The Association decided that while the annexation of Cuba was beyond its purview, the second resolution should be carried. Two months later, a circular was sent out by the Marine Hospital Service with instructions forbidding entry into a United States port of a vessel without a certificate from a designated health official stating that there was no person with leprosy aboard, or if there had been, such person had been removed.[8] With this action, leprosy became a matter of maritime control.

Both Dr. Joseph Y. Porter, State Health Officer from 1889 to 1917 (Fig. 1), and Dr. R. D. Murray, Surgeon, Marine Hospital Service, Key West, acknowledged in official reports that leprosy had existed as an open secret in Key West for some time, and had been treated there by local physicians. The reports of both doctors referred to items in northern newspapers around 1889 or 1890 alleging the employment of leprosy victims in the cigar factories in Key West. The accounts of the two doctors agreed in general that in 1888 a person who claimed to be a leprosy expert came to Key West and soon reported that he had observed over 100 cases of leprosy in the city. His "meddlesome and impudent intrusion into private families"[9] earned him a horsewhipping, and he departed quickly for Tampa, where he made similar charges, with, according to Dr. Porter, similar results. Dr. Porter referred to this person as "Burger"; Dr. Murray, writing almost ten years later, referred to him as "Dr. E. C."

Dr. Porter was concerned about the efforts to discredit Florida's commercial interests. "Rival companies or individuals, jealous of the general prosperity of the State, have tried various ways, through reflections upon its health, its coast protection system and its cigar industry, to effect that which legitimate competition in trade has failed to accomplish."[10] The newspaper publicity caused the State Health Officer of Texas temporarily to forbid ship communication between Key West and Galveston, until Dr. Porter reassured him that there was no danger from either passengers or tobacco freight. Proposed investigations by the city commissioners of Key West, a committee of local physicians, and the cigar manufacturers came to naught.

Dr. Murray's account dealt with information about specific patients. He also said that having observed the almost constant presence of both yellow fever and leprosy in Key West, he had been instrumental in having adopted an ordinance requiring the issuance of death certificates, as well as other registrations. The ordinance produced limited results, however, and writing retrospectively in 1902 he commented: "I regret to state that the execution of the law is not productive of the benefits I hoped for. I think all the leprosy death certificates recorded are signed by me. For family reasons doctors write pneumonia, blood poisoning, athrepsia, and other obscure titles when a leper dies."[11] (During the same year, Dr. Murray stated that he personally knew of 18 leprosy patients who had lived in Key West.)

At the 1891 session of the Florida Medical Association, serious notice was taken of the leprosy situation in Florida. Dr. R. P. Daniel delivered a comprehensive report titled "The Leprosy Problem." He expressed limited confidence in the effectiveness of the quarantine circular of 1889 by saying, "There are many irregular channels which I fear cannot be thus supervised."[12] Disclaiming his own knowledge of leprosy in Florida except for the alleged cases in Key West, Dr. Daniel requested information about any others in the state. As if in quick response, a death from leprosy was reported in Pensacola be-



Fig. 1.—Dr. Joseph Y. Porter, State Health Officer, 1889-1917.

fore the 1891 Proceedings were published, and the New York Times, June 3, 1891, reported the like death of a longshoreman in Jacksonville.

Not all the members at that meeting agreed that a leprosy problem really existed in Florida, but at Dr. Porter's suggestion, the Section on Medicine was instructed to report further on the situation at the next meeting. In 1892, Dr. Warren E. Anderson so reported and agreed with Dr. Porter's advice that a hospital should be built on Mullet Key for all the leprosy patients in Florida. The matter was then referred to the State Board of Health.

As State Health Officer of the Board of Health, Dr. Porter was more specific in his recommendation to that body, as follows:

> It is advised that a settlement of small one-story buildings be established at Mullet Key for the care of lepers that may be found in the State. The houses could be increased in number as required. For the present two only will be necessary. The services of the physician in charge of the Disinfecting Station at Mullet Key, who is a capable and efficient officer in addition to his other duties, can be had for the medical care of this unfortunate class.[13]

Dr. Porter considered that Mullet Key was large enough to accommodate such a settlement apart and isolated from the new disinfecting facility.

In those years, maritime quarantine was the major public health activity in Florida. Dr. Porter was alert to the problems involved, particularly as they concerned leprosy. Correspondence of 1893 and 1894 from Dr. Porter to Surgeon General Walter Wyman shows the kinds of answers he sought. Does a city physician appointed by the customs collector have the authority to issue freedom from leprosy certificates to vessels, or is this the sole responsibility of the port quarantine officer? What is the port physician's responsibility in admitting a leprosy victim who develops symptoms only after his arrival in the country? Should physicians be required to report the names of leprosy patients and yet not divulge the names of sufferers of diseases more dangerous to the general public health, such as tuberculosis and syphilis?

In one of these letters, Dr. Porter described his efforts to deal with the problem. "As State Health Officer I have ordered a registration . . . to obtain information of all lepers here [Key West] or elsewhere in the State and will distribute printed advice to the patients, their families and friends, how to prevent the disease being communicated or conveyed to others through inoculation."[14]

The idea was born early that the solution to the leprosy threat must eventually come on a national level, rather than through local or state efforts. Because of personal observations in Havana and reports of United States consuls, Supervising Surgeon General Wyman declared in 1891 that decisive steps were needed to stop the introduction and spread of leprosy in the country. As a preventive measure for the latter, he expressed his belief that a national leprosy hospital should be established.

In 1894 Dr. Wyman suggested the formation of a Commission to investigate and report on the prevalence of leprosy in the country and to make recommendations for its control. Congress passed a law establishing such a Commission in 1899. The results of its investigation were released three years later and while the published statistics were considered lower than the actual number of victims, especially in the Gulf states, the report itself was significant as a basis on which to consider both the national problem and the recommendations of the Commission.[15] What the report revealed about the situation in Florida was surprising to many people.

The Report of 1902 and Afterward

The study of leprosy conducted by the Commission of three medical officers of the Marine Hospital Service was the most comprehensive that had been conducted in the United States. Thousands of state and county officials, secretaries of boards of health, dermatologists, and leprologists were contacted. Dr. Murray, as Surgeon of the Marine Hospital Service in Key West, was given a special acknowledgment in the introduction of the report for his assistance, and a letter from him to the Commission was included in its entirety.

Of the total 278 cases identified in the United States, Louisiana ranked first with 155; Florida and California were both second, each with 24 cases. The report showed clearly that although leprosy continued to be brought into the country from elsewhere, in a few specific foci, the disease showed evidence of occurrence among the American-born. The Key West area was such a focus.

Florida's 24 cases were analyzed by the Commission as follows: 17 males, seven females; five American-born, 18 foreign-born, one unknown; 19 probably contracted leprosy in the United States, five contracted it in unknown places; 24 patients lived at large; 23 patients had the anesthetic form of the disease, one was unknown. The county breakdown showed Monroe with 22 cases, Escambia with one, and Hillsborough with one. In addition, there was one suspected case each in Alachua, Hillsborough, and Marion Counties.

Florida reflected the national pattern in showing more male patients than female, more patients at

large than isolated, and more patients with the predominating form of leprosy, i.e., anesthetic, rather than the four other forms which were recognized at the time. Although it is probable that some of the 24 patients in Florida did contract their disease outside the United States, this was not established with certainty. Nevertheless, the nationality breakdown was pertinent: 12 Bahamians, six Cubans, five Americans and one unknown.

Recognizing the contagious nature of leprosy, even though contracted with difficulty, the Commission recommended the establishment of one or two national leprosaria under federal control for the care and treatment of its victims. Such habitations should be comfortable, attractive, and located in a salubrious climate. Suggested as ideal sites were the arid Southwest, a similar region farther north, an island off the Pacific coast, and an island in the Gulf of Mexico.

Although the Commission stressed the need for early action by the Congress on its recommendations, congressional deliberations dragged on for 15 more years before the necessary law was passed, and it was four years after that before the National Leprosarium was established. During all this time, confidence persisted among many physicians and officials that such a facility would eventually materialize. In a report to the State Health Officer in 1917, one Florida physician deplored the lack of provisions for several recently diagnosed patients in Key West and he added hopefully, "The proposed national leprosarium will probably solve the problem."[16]

In 1889 the State Constitution gave the Board of Health responsibility for the supervision and maintenance of the public health. After a decade of increasing involvement with leprosy as it related to maritime quarantine and interstate transportation, the Marine Hospital Service took over the responsibility for this aspect of public health in 1901. But the management of the disease within the state still belonged to the Board and local officials.

A perusal of the publications of the Board of Health over the years shows the attention given to leprosy as one of the communicable diseases in the state. In 1892 the Board outlined burial requirements for deceased leprosy patients. As of 1902 the Board's Rules and Regulations required the immediate reporting of every case of leprosy by the attending physician or nurse or by any other person in attendance. Instructions appeared in the Board's fifteenth annual report, 1903, for the collection of material for bacteriological examination in supposed cases of leprosy. In both the 1912 and 1914 Rules and Regulations, physicians and officials were informed as follows:

> All persons affected with leprosy shall be continuously confined upon their home premises and kept off the public thoroughfares and out of public vehicles of transportation, or confined in such place as shall be designated by the State Health Officer. . . .[17]

As Health Officer, Dr. Porter had commented frequently since 1891 about the necessity for observing these precautions. Implementation of the rules proved unsatisfactory and inconsistent over the years. Stories exist about a brick wall being built around the home of a patient and his family in Palatka, about other patients who were almost totally isolated in hospitals, and about others who were rejected by their neighbors. One patient well known among officials around 1910 was a young orphan boy who was placed in Duval County Isolation Hospital by the State Board. Because the State Attorney General advised that the Board did not have legal authority to do this, special legislative action was required to arrange for his continuing care there. After about four years, the boy escaped. On the other hand, a correspondent wrote to the Surgeon General from Oveido, Florida, about a patient who "rides by in his Ford and never alone, for the community in general . . . ride with him. . . . A few weeks ago he applied for a marriage license [and] was granted one. . . ."[18]

Several years later, in 1919, Dr. Porter felt compelled to defend the past handling of the leprosy problem, and he wrote,

> Neither the former state board of health **[sic]**, nor myself . . . was satisfied with the unsatisfactory management of preceding years, but there was no appropriation for a leper colony in the state by the legislature or by the state board of health **[sic]**, no location where it might be placed. . . .[19]

Dr. Porter, as State Health Officer, showed a special interest in leprosy. Until 1917, the year of his resignation, most of the official reports and letters regarding leprosy in Florida were written by him. In 1910 he reported that he had sent an assistant to Cuba to study leprosy in the excellent facilities available there. Later, Dr. Porter queried Surgeon General Rupert Blue in a telegram as follows:

> Press dispatch . . states that British . . . schooner SUCCESS from Barbadoes bound for Philadelphia . . . to be in distress off Florida Coast today. Also states has seven lepers on board. Investigation fails to ascertain whether vessel has grounded or landed crew. Can bureau learn . . . if assistance has been given?[20]

He received a return wire the same day advising him that when last seen, the schooner was proceeding

under her own sail. Even two years after his resignation in 1917, Dr. Porter was to have a public role to play in the story of leprosy in Florida.

The Site and the Fight

Residents of Jacksonville woke up to this headline in the Florida Times-Union on the morning of September 18, 1919: "COLONY OF LEPERS OFFERED TO FLORIDA BY THE GOVERNMENT; CONGRESSMAN FRANK CLARK HAS ADVISED THE CITIZENS OF HIS DISTRICT TO FILE VIGOROUS PROTESTS AGAINST ESTABLISHING SUCH A COLONY IN FLORIDA."[21] On November 30, 1919, another headline appeared: "LEPER COLONY WILL NOT BE LOCATED HERE."[22] During the 73 days between these two banners, controversy raged with a rare intensity in the state, and eventually involved local, state, and national political figures, possibly including the President of the United States; health officials of the state and national governments; physicians from all over Florida; the presses of the state; organizations such as chambers of commerce, fraternal organizations, and boards of trade; the heads of the state's higher academic institutions; and, in one way or another, a goodly portion of the populace of Florida.

Earlier in the year, in January, interest had been revived in a national leprosarium. The next two years were to be the last big push before the long sought facility came into being. Two years before, on February 3, 1917, Congress had at last enacted legislation for such a place, to be administered by the United States Public Health Service. The Surgeon General had immediately appointed a Board to scout for possible suitable sites across the country. Within two months, however, the United States had entered World War I, and wartime concerns had taken priority. Afterward, the influenza epidemic required the attention of Public Health Service officials, including the Chairman of the Board for Selection of a Site for the Federal Home for Lepers, Dr. George W. McCoy (Fig. 2).

During 1919 the Board members travelled around the country visiting likely sites. Their task was not enviable. Once their mission in a community was known, they were faced with hostility and occasionally personal danger. By September 1919, 18 locations had been inspected, seven of these in Florida, namely, Homosassa Island; North Mullet Key; Long Key; Lacosta Island; Tampa Quarantine Station; a tract near Brooksville; and as one site, three islands lying off Cedar Key — North Key, Snake Key, and Seahorse Key.

Several of the locations had proved unsuitable. Others, such as Angel Island off the California coast, while considered ideal to the Board, had to be dropped because of local pressure. North, Snake, and Seahorse Keys, comprising some 400 acres, were among the last places visited. To the Board, they presented definite advantages: (1) Favorable climate, (2) Territory that already belonged to the federal government and was unused, (3) Separation from the mainland, and (4) Accessibility to the mainland. Because Snake and North Keys belonged to the War Department and Seahorse Key belonged to the Commerce Department, no take-over of state lands would be necessary. The roughly five-mile separation of the three islands from the mainland offered protection for the public health; yet the islands had accessibility to the mainland through Cedar Key or any seaport.

Preliminary evaluations had already been made of the topography, soil, and water supply. On September 9, Dr. McCoy wrote to Surgeon General Blue, "These islands have been recommended as the best available site and at the time of the writing of this report the matter of their transfer to the Treasury Department is under consideration by the branches of the Government now having control of them."[23]

The investigators differed in their opinions about the most desirable site. The whole Board had liked Angel Island, but Surgeon General Blue was especially disappointed that it did not work out. Dr. McCoy was impressed with the Cedar Keys site. Mr. William M. Danner — lay member of the



Fig. 2.—Dr. George W. McCoy, Director, Hygienic Laboratory, United States Public Health Service, 1915-1937. (Reproduced from the collection of the National Library of Medicine.)

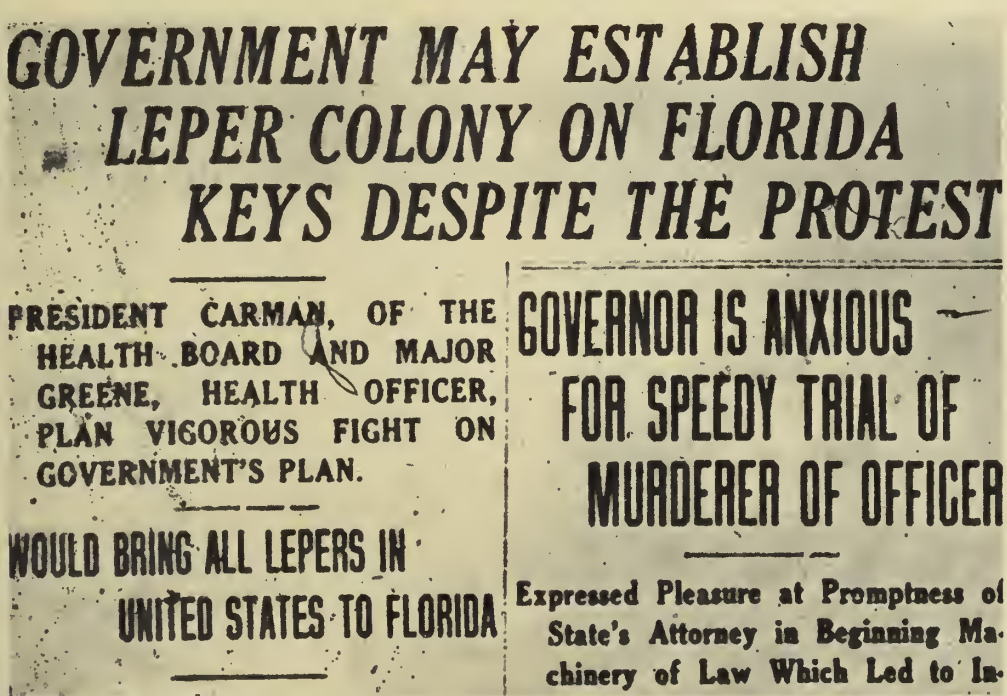
Board, chairman of the American Mission to Lepers since 1911, and one of the persons most responsible for keeping alive the idea of the need for proper facilities for leprosy victims — thought another location in Florida was also suitable. According to one source, "He [Mr. Danner] favored establishing a Home in a point somewhere in Florida, which he had selected, contending that it was ideal for various reasons, especially the fact that it was a high and dry country and was free from swamps, or waters."[24]

On August 22, the Secretary of the Treasury, Mr. Carter Glass, had written to his counterpart in the War Department, Mr. Newton D. Baker, requesting the transfer of Snake and North Keys to the Treasury Department. In mid-September Mr. Glass approached the Acting Secretary of Commerce, Mr. E. F. Sweet, for the transfer of Seahorse Key. About 70 years before, the President had reserved Snake and North Keys for possible military purposes and Seahorse Key for a lighthouse. With the lighthouse now in disuse and with the lack of necessity for military occupation of the islands, the correspondence shows that the proposed transfers of the properties presented no difficulties. The War Department made no demands and Snake and North Keys were transferred forthwith to the Treasury Department. The conditions requested by Commerce were modest: "This Department is prepared to give the permit desired, provided the Treasury Department will provide . . . a suitable site on Depot Key for lighthouse purposes and will erect thereon a keeper's dwelling, an oilhouse, a 75-foot galvanized observation tower, and a boat landing."[25]

The Board urged speedy transfer of the three islands to the Treasury Department. Considering the Cedar Keys location as the best available site, and wary from experience, Dr. McCoy wrote, "An effort may be made to block us unless we get the transfer promptly."[26]

Dr. McCoy's fears were soon realized. Three days after the Florida Times-Union carried the headline announcing that the nation's leprosy home was being offered to Florida, Governor Sydney J. Catts issued a proclamation denouncing the proposed facility. Referring to the original news item (that had described the possible action as a calamity), he urged all citizens and organizations to protest to their representatives in Washington by submitting petitions. The cause was taken up, and letters started pouring into the capital. One resident from the fishing village of Cedar Key wrote, "We resent the thought of having it here to ruin our little town and break up our homes—which it will do. . . . Please, please, locate these poor unfortunates some place else."[27]

By September 30, the President of the State Board of Health, Mr. Joe L. Earman, and the State Health Officer, Dr. Ralph N. Greene, publicly agreed



GOVERNMENT MAY ESTABLISH LEPER COLONY ON FLORIDA KEYS DESPITE THE PROTEST

PRESIDENT CARMAN, OF THE HEALTH BOARD AND MAJOR GREENE, HEALTH OFFICER, PLAN VIGOROUS FIGHT ON GOVERNMENT'S PLAN.

WOULD BRING ALL LEPERS IN UNITED STATES TO FLORIDA

GOVERNOR IS ANXIOUS FOR SPEEDY TRIAL OF MURDERER OF OFFICER

Expressed Pleasure at Promptness of State's Attorney in Beginning Machinery of Law Which Led to In-

Fig. 3—The Florida Times-Union, September 30, 1919. (Reproduced from the collection of the Library of Congress. Used with the permission of the Editorial Department, Florida Times-Union.)

that Florida would suffer incalculable injury (Fig. 3). When interviewed, the health officials not only pointed out the threat to Florida's tourist interests, but suggested that a medical hazard might also exist in that visits by friends and relatives to patients could result in the development of new cases of leprosy. The Panama City Pilot reminded all concerned that another danger was present. Lying in the Gulf of Mexico, the Cedar Keys were often swept by heavy winds, and in 1842 a hurricane inundated all the area and blew from its foundations a general government hospital on one of the islands.

In Washington, Florida Senator Duncan U. Fletcher sent back word that although Surgeon General Blue hoped the plan would eventually be accepted by Floridians, it would not be forced upon them.

In mid-October Governor Catts addressed the people through the Florida Times-Union. He announced that a delegation of prominent Florida citizens would soon accompany him to Washington to aid the state's representatives in their efforts to prevent "this dire calamity." He again pleaded for support, this time including the heads of Florida's higher academic institutions, all boards of trade, and all chambers of commerce. Dr. Greene announced his intention of going to Washington too. In the meantime, the Governor and Dr. Greene visited Cedar Key, Bronson, and Williston and conducted a series of mass meetings to encourage the protests of the local inhabitants who, according to most reports, overwhelmingly supported their position.

A few days later, a prestigious party consisting of the Governor; Mr. T. R. Hodges, the Mayor of Cedar Key; Mr. Earman; Dr. Greene; and others made its way to Washington. There, on October 23, they conferred until far into the night with Surgeon General Blue. The outcome was that their lingering fears about the health dangers were put to rest and the only remaining obstacle was one of "cold, hard commerce." Everybody agreed that this obstacle was not so easily overcome. Although some officials pointed out that the existence of leprosy facilities in California, New Orleans, and Havana had not caused their important tourist businesses to suffer, there was undeniably no expert who could predict with assurance the extent to which the cigar industry, the fruit industry, the $40,000,000 fishing industry, or the annual tourist presence in Florida might be affected.

Within two weeks the Duval County Medical Society adopted a resolution stating that, from a medical point of view, a leprosy colony in Florida should have no opposition. They suggested instead that the medical profession in the state should devote its energies to a program of educational propaganda to show its citizens that a properly controlled facility would not be disadvantageous in any way, and would be advantageous in caring for the state's victims.

The remainder of the month of November 1919 presented nothing new in the headlines. The public outcry was not as loud during that month. To the many Floridians who were convinced that the government would have its way in the end, it must have seemed that the decision had already been made. Toward the end of the month Senator Fletcher wrote to Treasury Secretary Glass reminding him again that there were still very strong feelings among all groups and persons in Florida against the proposed leprosarium at the Cedar Keys site. The Senator received this reply from Mr. Glass within days:

> I beg to advise in view of the representations made by you that there is violent and pronounced opposition to the location in the state of Florida of a national home for persons affected with leprosy and in deference to your wishes in regard to the matter, it has been decided after mature consideration not to approve the recommendation of the board that a home be located in the state.[22]

With one sentence, this public health controversy that had shaken the state for ten and one-half weeks was stilled.

The cast of characters who participated in this episode in Florida's medical history was impressive on the national, state, and local levels. Senator Fletcher was the most active of the Florida representatives in Washington. Both Governor Catts and Mr. Hodges urged him to take advantage of his close relationship with President Woodrow Wilson to have the Board's recommendation regarding the Florida site rejected. In a letter dated October 3, 1919, the Governor suggested to Senator Fletcher that if President Wilson refused a personal appeal and balked at interfering in the determination of the Public Health Service to use the Cedar Keys site, the Senator "would be justified in refusing to cooperate with the President in some matters of vital importance to himself. . . ."[23]

On the other hand, according to a newspaper account written 25 years later, Mr. Hodges' role in the affair had been similar and critical (Fig. 4). The Governor was an avowed candidate, attempting to succeed Senator Fletcher in the Senate in 1920, and this fact was Mr. Hodges' "winning card." When it seemed that the Public Health Service was



Fig. 4.—Captain T. R. Hodges in his United States Naval uniform, World War I. (Used with the permission of Miss Louise Hodges, Gainesville, Florida.)

going to insist on the Florida site, Mr. Hodges reminded the Senator of the numerous letters of protest received in Washington from Floridians. Also referring to the Senator's entree to the White House, Mr. Hodges asked him if he wanted to be reelected to his office the next year. The answer was affirmative. "Then Captain Hodges asked what he should tell the people of Florida on his return and the senator replied, 'You may tell them there will be no leper colony established in Florida.' "[29]

Whether or not the Senator and President Wilson ever discussed the matter is unknown. The Public Health Service had continued to declare that it would not insist on the Cedar Keys site if the residents remained adamant in their opposition to it. Governor Catts failed in his bid for the Democratic senatorial nomination in 1920; Senator Fletcher was reelected and served in that post until his death in 1936.

Three other active players in the drama were the representatives of the Florida State Board of Health, Mr. Earman, the President; Dr. Greene, State Health Officer (Fig. 5); and Dr. Porter, former State Health Officer. The stand of Mr. Earman and Dr. Greene remained unchanged throughout — commercially, Florida would suffer immeasurably if the national leprosy home were brought to it — and they gave strong support to the Governor's campaign. When Dr. McCoy visited Florida to investigate the source of the objections to the site, he called on Mr. Earman. During this visit, Mr. Earman conceded that there was no danger from a medical or sanitary point of view, but because the Governor, various commercial bodies, and some of the state representatives objected to the facility, he felt it necessary to take the same official attitude. In 1920, Dr. Greene wrote about the events of 1919 in his annual report to the Board: "The State Board of Health, while not objecting on medical grounds to the establishment of a national leprosy hospital in Florida, did object on the ground that it would work a commercial injury that would be far-reaching and disastrous."[30]

Dr. Porter, now Quarantine Inspector at Key West, saw the matter differently and made his views known through a lively exchange of letters with Dr. Greene in the Florida Times-Union during October 1919. Dr. Porter considered the proposed leprosy facility just off the Florida coast a rational solution to an old problem and he deplored what he called the hysteria that was being generated by the state's leaders. He pointed out that the proper function of a health board was "to teach, and educate and calm unreasonable fear"[31]

There were other dissenting voices. Besides Dr. Porter's own outspoken views, he also reported that the Monroe County Medical Society had signed a resolution of approval for a leprosy home to be established on the Cedar Keys. A member of the Regular Board of Medical Examiners, Dr. E. Van Hood of Ocala, wrote to Surgeon General Blue that



Fig. 5.—Dr. Ralph N. Greene, State Health Officer, 1919-1921.

he favored a site on any of the Florida keys or in the center of the state in a more arid location that could be made into an oasis by planting grasses, oaks, and magnolia trees. State Senator J. W. Turner, a physician from Cedar Key, went on record in the newspaper as approving the site. And Dr. McCoy stated that he had talked with a number of Cedar Key businessmen, all of whom had expressed their willingness for plans to proceed. Dr. Greene estimated the dissent at no more than 10 percent.

One result of the few weeks of controversy was that, through the publicity, the state at large was made aware of the fact that there were leprosy patients in Florida and that they were inadequately cared for. Dr. Greene had held the post of State Health Officer only two months when the crisis concerning the site arose in September. The State Board of Health met early in November and 14 to 16 cases of leprosy had been identified by this time. At this meeting the Board allotted $2 per day to indigent patients deprived of their livelihood by their confinement at home. District health officers and city health boards were urged to contact patients in their locales and to visit them regularly. In addition, the Board requested the Public Health Service to send an expert to Florida to do a case-by-case survey of the state's patients and their families. (Dr. McCoy returned to Florida for this purpose in 1920. By now there were 12 known patients. Again his survey showed that the trail of leprosy in the state usually led to Key West.) Dr. Greene also stressed the importance of reporting all cases. In his report of 1920, the Health Officer commented that it was clear that the next legislature would have to take some action. The legislature did not, and the brief flurry of interest once again failed to alter the unsatisfactory situation.

The announcement came in July 1920 that the Louisiana Leper Home in Carville, Louisiana, would be taken over by the Public Health Service as the national home for the care and treatment of leprosy victims in the United States. However, even when the newly named United States Public Health Service Hospital No. 66 was officially transferred from the State of Louisiana on January 3, 1921, the states found that not all known patients could be immediately accepted. Procedures had to be established, rules and regulations worked out, money allocated, and new buildings erected. Although Dr. Greene had made an inquiry regarding admission of Florida patients in early February 1921, the following report was made to the State Board of Health in 1923:

> The leprosy situation in Florida appears to have changed but little in the past two years. . . . Attempts have been made from time to time . . . to secure the admittance of the people [16 patients] to the National Leprosarium . . . but without avail. Funds are not available for the erection of new buildings and until new buildings are erected no new cases can be accepted. It is necessary that each county care for its own lepers as they do their paupers until such time as the Government provides room for them at Carville.[32]

Nevertheless, four Florida patients were admitted into Carville in 1921 and five in 1922. None were admitted during 1923 and 1924, but by the end of the decade (between 1921 and 1929), 35 patients had been admitted from Florida and a total of 46 cases had been reported in the state.*

The realization of a national home for victims of leprosy had been painfully slow, but as of January 1921 the unique public health problem that for half a century had frustrated the United States — and the State of Florida no less — found itself a giant step closer to solution. The circumstances surrounding the presence of the disease in Florida often had a direct influence on the actions of the national government, including the culmination of efforts to establish the national facility.

The fate of the islands originally intended as a haven for leprosy victims was particularly fitting. Although North and Snake Keys had been officially transferred to the Treasury Department in September 1919, the titles were not actually delivered until 1925. Two years later, an attorney from the Cedar Key area requested permission to lease one of the islands for $50 a year as a vacation site for his family. His request was not granted. Sometime later, the islands were officially made into a bird sanctuary under the protection of the Coast Guard.

Summary

During the latter 19th century, American officials and physicians became concerned about the presence of leprosy in the Caribbean, where it had long thrived, and in Key West. Because of the open commerce between the southernmost city of the United States and the islands of the Caribbean, the disease was placed under maritime control by the Marine Hospital Service in 1889. A special Commission reported in 1902 that after Louisiana, Florida and California shared second place as the states with the most leprosy victims. Despite the Commission's recommendation for the early estab-

*Except for the figures in Table 1, all statistics in this paper were provided by the Clinical Branch, Epidemiology Department, United States Public Health Service Hospital, Carville, Louisiana.

lishment of one or two national leprosaria, nothing was accomplished until after World War 1. A Board that was appointed to consider appropriate sites attempted in 1919 to locate such a facility on three keys off Florida's Gulf Coast. Governor Sydney J. Catts led Floridians in opposing this action, and the matter was finally dropped on the basis that the state's commercial interests might be injured. The National Leprosarium was established in Louisiana in 1921, and by 1929, 35 patients had been admitted from Florida.

References

1. Romans, Bernard: A Concise Natural History of East and West Florida, New York, Printed for the Author, 1775; Reprint, New Orleans, Pelican Pub. Co., 1961, p. 167.
2. Ibid., p. 172.
3. Gussow, Zachary, and Tracy, G. S.: Stigma and the Leprosy Phenomenon: the Social History of a Disease in the Nineteenth and Twentieth Centuries, Bull. Hist. Med. 44:438, Sept.-Oct., 1970.
4. "Leprosy at Key West," New York Daily Tribune, June 26, 1881, p. 7.
5. National Communicable Disease Center: Leprosy Surveillance, No. 1, Jan., 1970, p. 8.
6. Lee, Benjamin: Do the Sanitary Interests of the United States Demand the Annexation of Cuba? Pub. Health Papers and Reports 15:47-52, 1890; Discussion, 15:289-296, 1890.
7. Allen, C. W.: The Inoculability of Leprosy, New York Med. J. 49:19, 1889.
8. [Circular] Regulation to Prevent the Introduction of Leprosy, Dec. 23, 1889, Annual Report of the Supervising Surgeon-General of the Marine-Hospital Service of the United States, Fiscal Year 1890, Washington, Government Printing Office, 1890, p. 11.
9. Porter, Joseph Y., Health Officer's Report, Second Annual Report of the State Board of Health of Florida, Jacksonville, March 29, 1891, Jacksonville, DaCosta Printing and Pub. House, 1891, p. 24.
10. Ibid., p. 23.
11. Letter from the Secretary of the Treasury Transmitting Letter from the Surgeon-General of the Marine-Hospital Service Presenting a Report Relating to the Origin and Prevalence of Leprosy in the United States, S. 269, 57th Congress, 1st Session, Washington, 1902, p. 91.
12. Daniel, R. P.: The Leprosy Problem, Proceedings of the Florida Medical Association, Session of 1891, Jacksonville, Times-Union Printing House, 1891, p. 80.
13. Porter, Joseph Y.: Health Officer's Report, Third Annual Report of the State Board of Health of Florida, Jacksonville, May 2, 1892, Jacksonville, DaCosta Printing and Pub. House, 1892, p. 34.
14. Letter from Joseph Y. Porter to Dr. Walter Wyman, April 11, 1894, p. 3, Record Group 90, General File 1897-1923, File No. 4712, National Archives Building.
15. Letter from the Secretary of the Treasury Transmitting Letter from the Surgeon-General of the Marine-Hospital Service Presenting a Report Relating to the Origin and Prevalence of Leprosy in the United States, op. cit., pp. 5-95.
16. Porter, Joseph Y., Jr.: Report, Twenty-eighth Annual Report of the State Board of Health of Florida, 1916, Jacksonville, Drew Press, 1917, p. 72.
17. Rules and Regulations of the State Board of Health and Statutes Relating to Public Health and the Powers and Duties of the State Board of Health of Florida [Jacksonville] Dec., 1914, p. 18.
18. Letter to Surgeon General Blue, Feb. 14, 1920, p. 2, Records of the Public Health Service, RG 90, General File 1897-1923, File No. 4712, NA.
19. "Dr. Porter Replies to Dr. Ralph Greene," Florida Times-Union, Oct. 22, 1919, p. 9.
20. Telegram from Dr. Joseph Y. Porter to Surgeon General Blue, Feb. 5, 1912, p. 1, Records of the Public Health Service, RG 90, General File 1897-1923, File No. 4712, NA.
21. "Colony of Lepers Offered to Florida by the Government," Florida Times-Union, Sept. 18, 1919, p. 5.
22. "Leper Colony Will Not Be Located Here," Florida Times-Union, Nov. 30, 1919, p. 3.
23. Letter from G. W. McCoy to the Surgeon General, Sept. 9, 1919, p. 3, Records of the Public Health Service, RG 90, General File 1897-1923, File No. 4712, NA.
24. Sister Hilary Ross: The Louisiana Leper Home 1894-1921, 1959, p. 89. Unpublished notes.
25. Letter from E. F. Sweet to Secretary of the Treasury, Sept. 19, 1919, p. 1, Records of the Public Health Service, RG 121, Title Papers, North Key, Florida, Snake Key, Florida, Entry 80, NA.
26. Letter from G. W. McCoy to Assistant Surgeon General J. C. Perry, Aug. 20, 1919, p. 1, Records of the Public Health Service, RG 90, General File 1897-1923, File No. 4712, NA.
27. Letter to Surgeon General Blue, Oct. 7, p. 4, Records of the Public Health Service, RG 90, General File 1897-1923, File No. 4712, NA.
28. Letter from Sydney J. Catts to Senator Duncan U. Fletcher, Oct. 3, 1919, p. 1, Records of the Public Health Service, RG 90, General File 1897-1923, File No. 4712, NA.
29. "Defeat of Leper Colony," Levy County Journal, Oct. 11, 1945, p. 3.
30. Greene, Ralph N.: Report of the State Health Officer, Thirty-first Annual Report of the State Board of Health of Florida, 1920, Jacksonville, n.d., p. 8.
31. "Dr. Joseph Y. Porter Advocates Location of Leper Colony," Florida Times-Union, Oct. 17, 1919, p. 11.
32. Turck, Raymond C.: Report of the State Health Officer, Thirty-second Biennial Report of the State Board of Health of Florida, 1921-1922, Jacksonville, n.d., pp. 9-10.

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Leprosy in Florida Today

Currently there are about 50 patients with Hansen's disease being followed at the Leprosy Clinic at the Mt. Sinai Medical Center on Miami Beach and 18 patients from Florida in the National Leprosarium at Carville, Louisiana. Almost all of those being followed at the clinic are immigrants who acquired their disease in the country of their origin; as far as is known there has been no transmission of this disease in Florida in several decades. Indeed, according to the National Center for Disease Control, there has been a decrease in the number of cases in Florida probably due to the arrival of fewer immigrants from Cuba and Puerto Rico.

State law requires that each newly discovered case be reported and, if infectious, be isolated until it shows no clinical activity and is bacteriologically negative on at least six monthly examinations. Isolation may be carried out at the National Leprosarium, a state or territorial leprosarium; or in the patient's home, if adequate facilities exist. Quarantine is not required. Reports pertaining to cases of leprosy are held in strict confidence and names are not divulged. Since 1970, U.S. immigration policy has permitted legal entry of persons with noninfectious leprosy; i.e., under treatment or those who have been treated.

Leprosy is only mildly communicable and those at risk are almost exclusively the family, especially the children. There has never been a case proven to have been contracted by medical personnel caring for a patient. The patient suffers most from hiding his case, for the disease can almost always be arrested by present-day drug therapy if treatment is begun early.

The Romantic Necrophiliac of Key West

Alvan G. Foraker, M.D.

Abstract: An unusual case of necrophilia, wherein an aged German, with some scientific background, embalmed the body of his Key West Cuban girl friend is presented. He kept the body in secret for some years. The possible effects of his education, including studies in German Romanticism, on his necrophilic acts, are reviewed.

Prior to World War II, when the rest of the United States was still in a post-Victorian, Protestant ethic straitjacket, Key West tolerated almost any eccentricity.[1] Ernest Hemingway[2] epitomized the casual ways freely accepted in the Keys, professional and semiprofessional prostitutes, developing and full-blown alcoholics, Bohemian pseudoartists, ex-rum runners, and remittance men contributed to the cosmopolitan flavor of the islands. Key West was a microcosm of service personnel, active and retired Army, Navy, Marines, Coast Guard, and Public Health Service. Observation suggested that many were stationed in the Keys or had drifted there because of failure to hack it on the mainland or to conform sufficiently to the fairly elastic mores of the services.

In this era occurred an incident which strained even the tolerant Conchs (natives of the Keys) and exceeded the most lurid passages in Krafft-Ebing.[3]

Case Report: Fact

Around 1930, there appeared in Key West Karl Tanzler Von Cosel, a German in his sixties. He said he was a count with nine college degrees, had been an officer in submarines in the German Navy in World War I[4] and received a pension. He obtained employment as an orderly and x-ray technician at the U. S. Marine Hospital.[5] On several occasions his wife, somewhere in Florida, wrote to the doctor in charge of the hospital asking for financial support for herself and her two daughters with no apparent result.[6]

Elena Hoyos Mesa, a Cuban girl in her twenties, came to the hospital for a chest x-ray because of progressive tuberculosis.[7] Her husband had left her and she was living with her impoverished parents. Tanzler became enamoured with Elena, brought her gifts and talked of marriage (Fig. 1).

During this period Von Cosel also constructed an airplane (Fig. 2) in a shed behind the Marine Hospital. Elena's tuberculosis progressed and she died October 25, 1931.[7] Von Cosel attempted to revive her with an electrical device. Some months after her burial, he built an elaborate above-ground vault for her remains.

In 1933, there was an evanescent "economy wave" during which Von Cosel lost his job at the hospital.[5] He was the type that is first fired since his peculiarities were extreme even for that tolerant environment. He towed his airplane off to a shack where he lived quietly. Apparently he was supported during this period largely by his pension from the German Navy.

When I arrived in Key West in July, 1940, Von Cosel was the most extreme of the town eccentrics. He lived in his shack and played Wagnerian music on a pipe organ[4] constructed by himself. At intervals he visited Elena's tomb in the public cemetery where he was said to talk to her on a specially installed telephone.[5]

In October, 1940, it came to light that Elena's body was not in the mausoleum but in Von Cosel's shack on the beach. The embalmed body was seized by the police, and an autopsy performed in a local funeral parlor. I attended this autopsy on the desiccated corpse (Fig. 3) which had a reconstructed face, breasts, arms, legs, trunk and a vaginal tube constructed so that intercourse could be simulated.

Von Cosel was jailed but was freed by the court since the statute of limitations had expired on his only crime—stealing a body from a grave. He became locally famous and pleaded for return of the body but this was denied. The remains were enclosed in a metal cube and secretly buried in a site now unknown. Some months later[8] Von Cosel was found to have reconstructed some sort of effigy

which lay in bed in his shack. In April, 1941, he left Key West, an event followed by an explosion at Elena's now empty mausoleum. He settled in Zephyr Hills, Florida, where he was found dead in his home in August, 1952. In one corner was a life-size waxen replica of Elena Hoyos Mesa.[7]

Case Report: Fancy

The facts have been given; the rest is conflicting recollections, rumor and speculation. Von Cosel told Dr. Julio DePoo,[8] a practicing physician of Key West, that in his castle in Germany while playing the organ he had a vision of a beautiful girl. Later he saw the same face on a madonna in a cathedral in Florence. Subsequently he recognized this vision in Elena. No information is available to indicate whether Von Cosel was a previous necrophiliac or an eccentric who turned to necrophilia because of his abnormal attachment for Elena.

How long did her body remain in the grave and the tomb which replaced it? Some[5] thought Von Cosel had the body in the airplane or his residence not long after death. Von Cosel said he removed the body from the tomb about two years after Elena's death, took it to the Marine Hospital, then in the nonflying airplane to his home. He said that he cleaned the remains[7] "rebuilt the lost parts, bandaged the broken parts and the destroyed parts which had to come out, I replaced. I put in sufficient absorbent material for packing to soak her in solutions and feed her and develop the tissues." He molded with plaster. In his shack, he created a bedroom where Elena lay on a large canopied bed, curtained with cheesecloth. He played the organ for her, emphasizing Wagner and felt she could hear the music. He continued to work on the airplane, alleging that when finished, "it would carry them both high into the stratosphere, so that radiation from outer space could penetrate Elena's tissues and restore life to her somnolent form.[7]"

Did Von Cosel really believe all those things? He was eccentric, no doubt, but did he promulgate some of these weird beliefs as a cover for his necrophilia?

Despite his eccentricity, Von Cosel liked the notoriety the case brought him and tried to capitalize on it. Years later, while living in Zephyr Hills, he wrote to a friend in Key West[9] that he was writing a history of the events entitled "The Secret of the Tomb." He said, "There is now a real chance that we can both become rich after all." So he had a good vision of the main chance. This manuscript, 70,000 words with 70 pictures in color and black and white, is unfortunately not available at present.



Fig. 1.—Von Cosel with a photograph of Elena.*



Fig. 2.—Von Cosel with the airplane, constructed by himself, in which he planned to fly away with his revived beloved Elena.

*Photographs by Miami Herald



Fig. 3.—The embalmed and prepared corpse of Elena.

Medical Literature Review

A search of the available psychiatric and forensic medical literature has revealed no duplicate of the Von Cosel case. Most references, such as Krafft-Ebing,[3] discuss necophilia involving recently deceased female corpses. Two pertinent comments are: "I have searched the 40-50 years accumulation of literature in sex crimes and related problems and have found no case as yet similar to this one."—William G. Eckert, M.D., Editor, INFORM, International Reference Organization in Forensic Medicine and Sciences.[10] "This is by far the most bizarre case of necrophilia I have come across."—Joseph C. Rupp, M.D., Ph.D., Medical Examiner, Corpus Christi, Texas.[11]

Von Cosel and German Romanticism

Certainly Von Cosel had a solid German education which exposed him to "Romanticism." The romantic movement in German Romanticism is heavily concerned with death. This background may have been involved in his thoughts and actions in this case.

"The development of Romantic necrophilia seems to have undergone four stages: A philosophical source, a poetic attitude, a manifestation in literature, and finally a social aberration.[12]" Goethe's Faust stated a yearning for the infinite, which will bring peace. Schopenhauer emphasized the futility of human life. Novalis[13] stated, "The dead are half alive, and the living half dead." He envisioned the dead as revelling in sensual delights. Wagner's[12] conception of love in death concludes most of his operas: The highest love cannot survive on earth, so the ultimate expression is for the living to commit suicide in order to join the departed beloved.

D. G. Rossetti, the poet, saw an afterlife filled with sensual lust ("The Blessed Damozel") and in his own life mentally dwelt in the grave with his wife ("The House of Life") whom he exhumed to retrieve his poetry which was buried with her. Edgar Allan Poe saw the highest of all possible topics for the poem as the love of a man for a dead woman ("The Philosophy of Composition").[12]

Next comes the translation of poetic notion to actual behavior. Praz[14] spoke of Romantic Necrophilia as distant from other necrophilia and assumed it was more self-conscious. He suggested that the Romantic "fascination of beautiful woman already dead" was influenced by the vampire legend. Praz cited some cases as evidence of behavior influenced by Romantic Necrophilia:

The composer Berlioz once stopped a funeral procession and had the coffin opened so he could "abandon himself to a delicious flow of gloomy mediations."

Perhaps the most famous case is that of Princess Beligioso (1808-71): "During a search by the Austrian police in 1848, there was found in a cupboard in a villa at Locate, belonging to the Princess, the embalmed corpse of her young secretary and lover Gaetano Stelzi, who had died of consumption a short time before. Instead of the corpse, a tree trunk had been buried."

By the end of the 19th century, the development of Romantic Necrophilia had about played itself out in Germany,[12] but it seems probable that Von Cosel was subjected to these influences during his education.

A striking example of necrophilia in the American literature is Faulkner's "A Rose for Emily."[15]

One of his classic Southern spinsters fed arsenic to a reluctant suitor, then kept his unembalmed body in a bed in a locked room for 40 years. "The body had apparently once laid in the attitude of an embrace."

Von Cosel and The Media

From the moment that Elena's body was discovered in Von Cosel's shack, the newspapers seized upon the case. There were repeated stories in Miami and other newspapers. Sunday supplements, such as the "American Weekly" of the Hearst chain, had romantic versions with ethereal drawings of Von Cosel kneeling at the gauze draped shrine wherein Elena's beloved body lay. None of these accounts gave the necrophiliac detail, although a small Miami scandal sheet presented this aspect. From time to time over the years, follow-up stories appeared in Miami papers, as at the time of Von Cosel's death. The definitive article on the episode was fully presented by Dorschner[7] in Tropic, supplement to the Miami Herald, March 5, 1972.

For some time after the original discovery in 1940, the case had considerable vogue in Cuban and other Latin newspapers and radio programs, which delighted in the morbid and romantic aspects of the affair.[8] A song, "Boda Negra" (Black Wedding) was inspired by the incident.

In 1971, while preparing an article on the U. S. Marine Hospital, Key West, I planned to include a short section on the Von Cosel case with the basic facts but with disguised names. As a middle-aged "square" I had not realized how much the times had changed until my attention was drawn to Dorschner's article in the public press, complete with true names, pictures, necrophiliac and anatomic facts, however sordid.

References

1. Foraker, A. G.: The United States Marine Hospital, Key West 1845-1943: J. Florida M. A. 59:37-41 (Aug.) 1972.
2. Hemingway, E.: To Have and Have Not. New York, Charles Scribner's Sons, 1937.
3. Krafft-Ebing, R.: Psychopathia Sexualis. London, Staples Press, 1965.
4. Griffin, W. W. (Cook, Marine Hospital, 1928-1943): Personal communication, 1971.
5. Moore, H. (Attendant, Marine Hospital, 1933-1943): Personal communication, 1971.
6. Mitchell, M. L. (Secretary, Marine Hospital, 1926-1943): Personal communication, 1971.
7. Dorschner, J.: The Love Story of Count Von Cosel. Tropic: The Miami Herald Sunday Magazine, Vol. 6, No. 10, page 20 (March 5) 1972.
8. DePoo, J. J.: Personal communication, 1971.
9. Von Cosel, K. T.: Personal letter, no date available, to Fernandez; Key West.
10. Eckert, W. G.: Personal communication (July 2) 1973.
11. Rupp, J. C.: Personal communication (July 23) 1972.
12. Hawthorne, M. D:. Personal communication (Dec. 13) 1972.
13. Brandes, G.: Main Currents in Nineteenth Century Literature, II. The Romantic School in Germany, New York, Boni and Liveright, 1923.
14. Praz, M.: The Romantic Agony. (translator, Davidson, A.) Cleveland World Publishing, 1956.
15. Faulkner, W.: A Rose for Emily. The Portable Faulkner (ed. Cawley, M.) New York, The Viking Press, 1967, pp. 435-444.
16. Villalon, A.: Boda Negra (Black Wedding). Tipografia Musical, Villegas 18, Havana.

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SPECIAL ARTICLES

Pensacola Musical Medics Find Harmonious Way to Serve

"The Medicine Men," a pop/Jazz-rock group, have found a way to get it all together for its members and serve others at the same time. Since they first performed for the local chapter of the American Cancer Society in March, they have appeared on local television for the ACS Cancerama fund drive and for the county chapter of the American Heart Association. Usually their performances are in some way medically related for hospital social functions, nursing homes or similar groups.

All are physicians with one exception and he's medically related. Mr. Jim Sullivan, bass guitar, is head of the Pensacola Education Program (PEP) finance department. Douglas Collins, director of Internal Medicine for PEP, leads the group on electric piano and vocals. B. L. Stalnaker, OB-GYN, performs on alto sax. Ronald Maddux, surgeon from nearby Milton, Florida, plays drums. Ted Veve, OB-GYN resident, plays electric guitar and assists with vocals. Norm Vickers, gastroenterologist, plays harmonica and guitar.

Drs. Collins and Stalnaker have previously had their own bands, so this musical activity is not new for them.

When the group gets together for weekly practice, they consider it their own musical relaxation therapy. Conversations may range easily between the finer points of a surgical procedure to amplifiers and augmented chords.

As one patient put it to his physician, "I'm glad to see that you can do something besides just practice medicine."



(Left to right) Dr. Doug Collins (electric piano); Dr. Ted Veve (electric guitar); Dr. Lou Stalnaker (alto sax); Dr. Norman Vickers (guitar); Dr. Ron Maddux (drums), and Mr. Jim Sullivan (bass guitar).

FMA Convention 1976
A Student Delegate's Report

Joel K. Lipman

The FMA Convention was held at the Diplomat Hotel in Hollywood, Florida from May 5-9, 1976. I was recognized as the first student delegate to the FMA House of Delegates. According to a resolution passed at the preceding year's convention, each medical school was allowed to have a student delegate added to that respective county's Medical Society representation at the convention, hence my position was born.

I have always been somewhat skeptical of organized medicine, thinking that they were basically self-righteous people only concerned with their own wellbeing. This line of thought rapidly diminished once I attended the Reference Committee meetings and the House of Delegates. Through the help of other members of the Alachua County Delegation, I was exposed to much of the inner workings of the organization and received a privileged view of how organized medicine can really work at its optimum.

I feel that by looking at some of the topics of discussion, one can more readily judge for oneself what is of importance to this state society. The major topics will be presented under the Reference Committee responsible for that particular topic. This list of topics is by no means complete.

I. Health and Education

A. Fifth Pathway—Each individual school will be given the prerogative whether to or not to accept students into their school via an alternate mechanism to the Fifth Pathway.

B. PIMS Programs—Recognition of the fact that its federal grant will be expiring and up for renewal.

C. Discussion of continuing medical education at Community Hospital and the number of hours required of local medical doctors in their pursuit of continuing medical education.

D. Establishment of a fourth medical school for the State of Florida. Although initially thought to be a good public relations gesture, it was overwhelmingly agreed that the State already can't support the three medical schools it already has. Needless to say, this resolution was denied.

E. FMA going on record as being against prisoners being held at State Mental Institutions.

F. Opposition to the Nurse Practitioner Act.

II. Public Policy

The FMA recognizes the shortage of laboratory equipment at prisons and feels that prisoners are entitled to the same level of care as patients outside prison.

III. Finance and Administration

A. Contingency fees—the FMA is going to make the Florida Supreme Court aware of the fact that they feel that a large part of the malpractice problem is the contingency fees being too high. They are recommending that the Florida Bar take action against this problem.

B. One Hundred Dollar Assessment of Its Members—Each member of the FMA was assessed $100.00 this year in order to fund both a public relations and legislative drive to give the doctors of Florida a greater input on medical legislation of the state and also to make the Florida citizens aware of the physicians' plight on medical malpractice, etc.

C. The FMA recommends that state agencies hire doctors only to diagnose and treat mental and emotional disorders, instead of the nurses and psychologists presently being utilized.

D. The FMA is opening its membership to osteopaths who have completed one year of AMA approved graduate training program.

E. Interns and Residents will only have to pay a FMA membership fee of $10.00 instead of the previous $25.00.

Mr. Lipman, of Naples, Florida, is a member of the Class of 1977 at the University of Florida College of Medicine, and was a Student Delegate to the 102nd Annual FMA Meeting.

F. PIMCO (Professional Insurance Management Company)—A self-established malpractice insurance company set up by the FMA for its members. It carries lower premiums than other commercial programs available.
G. The House addressed the topic of death with dignity. This subject was sent to the Executive Committee for further consideration.
H. The FMA supports CPR education of the public and themselves.

IV. Legislation and Miscellaneous

Malpractice was discussed in detail, i.e.,—need for definition of malpractice, limitations of damages, etc.

V. Medical Economics

A. Workman's Compensation Fees—increased by 32% by the efforts of the FMA.
B. The FMA assigned to the Board of Governors for further study the resolution protesting policies of hospitals requiring medical staff members to carry professional liability insurance.

In the final evaluation of my experience at the 1976 FMA convention, I feel that they are a highly organized, very aware group of skilled professionals who, with little or no dissension from within, are actively attempting to protect the physicians and citizens of the State from any medical legislation which would lower the quality of medical care delivered in Florida. They are actively seeking solutions to their present problems and preparing for any problems that might arise in the future.

I was surprised at the number of delegates who came up to me and stated that they were glad to have a student delegate within the House. I see this position as student delegate to the FMA as being a valuable pathway toward creating greater communication between the medical students of the State of Florida and the Florida Medical Association.

Continuing Medical Education (CME) Report Forms To County Societies

FMA members should send their completed continuing medical education report forms to their county medical societies, not to the FMA headquarters, according to the Committee on Continuing Medical Education (CME).

Many members have been sending these reports to the FMA in Jacksonville, thus causing a delay in processing.

In a recent mailing to FMA members, the Committee on CME asked members to provide their "medical education number" on a return post card. This is an 11-digit broken number (i.e., 000 00 00 0000) that appears with the member's name in the Florida Medical Directory. The first five digits designate the member's medical school. The next two show the year of graduation; and the last four are an individual number. An explanation appears on Page 26 of the FMA Directory.

LEE ADAMS' "CADUCEUS"

A limited number of these lovely prints are still available for a $300 tax-deductible donation to the Florida Medical Foundation. If you wish to obtain a print, please act now as we have already made the "Caduceus" available to patrons of Lee Adams. Write or call FMA headquarters, 735 Riverside Ave., Jacksonville 32204 or phone (904) 356-1571, for details.

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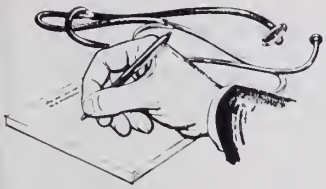
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Others Are Saying

Undergraduates: Your Responsibility

In the past three years we have seen a tremendous surge of interest by the medical students in Family Medicine. Before this time, there has always been an interest in Family Medicine during the first year of medical school but this interest dwindled by the time the medical student reached his final year. The reason for this is quite evident. First, medical students are very idealistic when they enter medical school. They care. They want to take care of people. By the time they finish basic sciences and experience rotations through numerous specialty clinics, they lose this enthusiasm. Their enthusiasm dwindles because they have no exposure to family medicine. They also have no role model to observe. Finally, the family physician is downgraded by being called a local M.D., who refers cases to the specialist because he does not have the knowledge to treat these patients.

This situation is changing very slowly in Florida schools. Family Medicine now has more definitive areas to teach in the curriculum. Students are also able to observe how a model family health clinic works. Their role models are the Family Medicine residents and faculty. The student not only sees good medicine practiced, but also observes an attitude of caring that permeates the whole Family Medicine department. The only deficit is that these family health units are still attached to large teaching institutions. Very few students actually see the inside of a family physician's office.

The family practitioner's office has always been considered a contaminated area for students. The contamination consisted of the large number of patients treated and the collecting of fees. In other words, fee for service is something that you do not think about until you are in practice. This concept parallels the virginity until marriage myth.

Medical school should encourage, and even insist, that the students experience private practice in primary care by observing the actual practice of a family physician. A student could more accurately assess his feelings about family practice. This exposure could encourage or discourage students from entering the specialty of family medicine. By doing this, students will be given a much broader base of observation in order to make their choice for a career.

Selection of family medicine preceptors should be made very carefully. Private practitioners should remember that a student will slow down his practice. But, in turn, the stimulation and interest by the young, future physician, will more than reward the physician for this loss of momentum. The preceptor should also be willing to spend time in the teaching centers to observe the newer methods of therapy that are being developed.

The concept "teach to learn and learn to teach" should be the goal of every family practitioner. As an added bonus, this activity is another way of earning prescribed credit for recertification.

Elliott Podoll, M.D.
Associate Professor of Family Medicine
and Pediatrics
University of Miami School of Medicine, Miami

Reprinted from the Editorial Page, Florida Family Physician, Spring 1976.

ORGANIZATION

A Review of Florida's Comprehensive Medical Liability Law — 1976

W. Harold Parham, D.H.A., and John Thrasher, J. D.

The Florida Legislature enacted a comprehensive medical liability law the last day of the Legislature on June 4, 1976, and it became law when signed by the Governor on June 27.

THE PROFESSIONAL LIABILITY LEGISLATION which was enacted includes the following provisions of the FMA Professional Liability Legislative Program:

- —Structured pay-out of future damages (The Senate-House Conference Committee amended this provision for structured pay-outs only when damages exceed $200,000)
- —Definition of medical professional negligence
- —Application of collateral sources in jury trials, as a direct offset
- —Definition of medical expert witnesses
- —Prohibit use of res ipsa loquitur doctrine in professional negligence actions

THIS LEGISLATION also includes:

- —A Remittitur-Additur provision which provides for the judge to lower or raise an award if, in his opinion, the jury verdict is clearly excessive or inadequate. (This provision was enthusiastically supported by the FMA).

A HOSPITAL RISK MANAGEMENT PROGRAM was adopted which provides for:

- —A mandatory program for all licensed hospitals
- —A method of advance payment for compensable injury sustained in the hospital as determined by a risk management committee (This is not intended as no-fault payments)
- —Mandatory insurance coverage or self-insurance for hospitals
- —The physician or hospital to obtain an absolute binding release from the patient for future liability

THE STATE PATIENT'S COMPENSATION FUND was amended to:

- —Limit payment of awards to $100,000 to one individual in any calendar year
- —Physicians participating in the Patient's Compensation Fund cannot be assessed more than one additional annual premium in any year

THE FMA PREVAILED IN ITS OPPOSITION to:

- —A mandatory patients compensation fund
- —Extension of the Joint Underwriting Association beyond its current three year life
- —Compulsory professional liability insurance for all physicians practicing in hospitals

THE FMA WAS UNSUCCESSFUL IN ITS EFFORTS to have legislation enacted which would:

- —Establish an absolute two year statute of limitations
- —A limit on general damages
- —Recovery of defense cost, (this was passed by the House but defeated in the Senate-House Conference Committee)

IN MAY, THE FLORIDA SUPREME COURT voted unanimously to uphold the constitutionality of pre-trial mediation panels in medical negligence suits. (The FMA participated by filing a brief in support of the Constitutionality of the Statute.)

THE FLORIDA SUPREME COURT has not ruled on the Florida Bar's petition setting a limit on contingency fees for attorneys (the FMA has filed a brief requesting the Court to modify the Florida Bar's petition, by lowering the limits).

A SUMMARY OF THE MAJOR PROVISIONS OF THE NEW COMPREHENSIVE MEDICAL LIABILITY LAW FOLLOWS:

- —THE MEDICAL LIABILITY COMMISSION which was established by the Legislature last year to

Dr. Parham is Executive Vice President of the Florida Medical Association. Dr. Thrasher is FMA Legal Counsel.

conduct a one-year study of malpractice insurance, is extended for an additional year under the jurisdiction of the Insurance Commissioner.

—MANDATORY RISK MANAGEMENT PROGRAM —Every hospital, ambulatory surgical center, health maintenance organization, or other facility of in-house patient care must establish an internal risk management program. (Previously, only hospitals having more than 300 beds were required to do so.) Two or more facilities may combine their risk management programs.

The risk management program is the responsibility of the facility's governing board and must include a system of reporting adverse medical incidents to the risk manager and a system of compensating patients upon the finding of a compensable medical injury.

Risk management innovations beyond those required by the bill are encouraged.

—FINANCIAL RESPONSIBILITY — Each facility must carry insurance or show financial responsibility for the purpose of compensating certain patient injuries. The Department of Insurance shall make rules and will audit every hospital's risk management and patient compensation program annually.

The Department of Health and Rehabilitative Services is responsible for setting up a data processing and statistical compilation system using information from medical incident reports.

Information obtained will be used in determining licensure and certification qualifications of health care facilities. An annual report of statewide statistical information will be made by the Departments of Insurance and HRS to the Governor and Legislature.

Each facility must set up a four-man incident committee comprised of the chief of the medical staff, the presiding member of the facility's governing board, and their two appointees. A fifth member can be appointed if needed to break a tie vote.

The physician and the health care facility shall agree to be bound by the findings of the medical incident committee, subject to arbitration and judicial review. Physicians and their facilities may agree to a unified defense if they are both joined in a suit. Releases are permitted, but any release negotiated must be approved by the medical incident committee.

Every health care professional or employee of a health care facility has a duty to report medical incidents to the risk manager.

The risk manager shall investigate each medical incident which comes to his attention. After investigation, he may convene the medical incident committee to determine whether the patient should receive compensation. Informal guidelines are provided for determining whether a compensable injury occurred.

If a compensable injury is found, the committee may or may not offer the patient compensation. The committee is given broad discretion in determining how much, if any, compensation will be offered. If treatment or services are offered in lieu of money, the customary value of such services shall be recorded.

The risk manager must inform the patient, in writing, of the amount of any compensation offered. The patient may either accept or refuse the offer. Full disclosure of the consequences of accepting any compensation is required. If the patient accepts compensation, he must sign a written waiver; and the following conditions apply:

a) Any claim based on the same incident must be filed within 2 years.
b) The value of any compensation paid in the form of money or free services shall be deducted from any damages awarded and repaid to the party who provided the services.
c) General damages (intangible losses) are limited to $250,000.

The offer of compensation and the finding by the incident committee that a medical injury occurred shall not be construed as an admission of negligence or guilt in any later court action.

Reports, findings, and actions of the incident committee, any state agency, or any licensing agency in regard to a medical incident are excluded from evidence in any later trial. The risk manager, medical incident committee members, and anyone who reports a medical incident are immune from civil or criminal liability for their actions if they act in good faith.

Upon receipt of any incident report, the risk manager must notify the parties named

in the report and furnish them with a copy of the report and reasonable notice of any hearing.

—PHYSICIAN'S LIABILITY—Whenever the medical incident committee determines there is a medical injury and that compensation should be paid, it must determine if there is any liability on the part of the physician. The physician may be assessed for the share of the compensation equivalent to his degree of responsibility. The physician's insurer shall be notified of and be bound by the committee's determination of liability. The medical incident committee shall determine the percentage of fault attributable to any party involved. Such determination shall be binding in a court of law.

Findings of the medical incident committee as to liability and assessments can be submitted to binding arbitration and are subject to the same standards of judicial review as civil decisions of a circuit court.

—BREACH OF CARE—A determination that a breach of care has occurred shall be reported to the appropriate licensing authority. If three such reports are received within one year, the authority shall investigate.

—THE STATE PATIENTS COMPENSATION FUND WAS AMENDED TO PROVIDE THAT:

a) Assessments and fees be prorated based on the portion of the year one participated in the fund.

b) A health care provider other than a hospital can only be assessed an amount equal to any fees and assessments originally paid for the year giving rise to the deficit necessitating the assessment.

c) When claims against the fund for any given year total more than $100,000, they will be paid out at the rate of $100,000 per person per year until full payment.

—THE COLLATERAL SOURCE PROVISION states that sources of insurance and other benefits (collateral sources of indemnity) will be subtracted from any judgment that the claimant gets in the suit. For example, if the claimant received an award of $5,000 from the jury and the claimant has had $2,000 in medical bills paid for by accident or health insurance, then the court will subtract that amount from the jury verdict and enter judgment after the subtraction—for a net recovery of $3,000.

The claimant will get credit for amounts he has paid for the benefits received (premiums for insurance), and the reduction in the verdict will be offset by these amounts.

—THE LAW DEFINES A "SIMILAR HEALTH CARE PROVIDER" FOR A PHYSICIAN, who is or holds himself out to be, a specialist as someone who is certified in the same specialty by the appropriate national board. A "similar health care provider" for general practitioners is someone licensed in Florida in the same discipline and who practices in the same or similar medical community.

—THE LAW EMBODIES THE RES IPSA LOQUITUR DOCTRINE and provides that the burden of proving professional negligence is to remain with the plaintiff at all times and the fact of the injury alone (except where a foreign body such as a sponge, clamp, forceps, or surgical needle is left in the patient) will not create any inference of negligence.

—ITEMIZED DAMAGES—If the jury finds the health care provider legally liable, it must itemize the damage award into the following categories: medical expenses, lost wages and other economic losses, and general damages (the intangible losses most often characterized by pain and suffering.)

The jury will further break down the award into the amounts in each of the categories which have already been incurred (past damages) and those awarded for expected future losses, expenses, and general damages.

—STRUCTURED PAYMENT OF DAMAGES—When the jury award for all **future** damages is $200,000 or more, then either party may request the court to require that those future damages be paid out over a period of time rather than in a lump sum, but the past damages will be paid immediately in a lump sum. The court, in its discretion, may order the periodic payment of the award over the period of time determined by the jury in which future losses

and expenses will accrue. This period of time is not necessarily the claimant's life expectancy.

If damages are to be paid out over a period of time and the claimant dies during that period of time, payments will cease except that the balance of expected wage loss will be paid into the claimant's estate in a lump sum. If the claimant does live until all periodic payments have been made, the payment will cease when the total amount awarded by the jury has been paid.

—THE REMITTITUR AND ADDITUR provided that upon request by a party to a suit the trial judge must examine the amount of the jury award in the light of all the circumstances of the case and determine whether it is "clearly excessive or inadequate." If the judge finds clear excessiveness or inadequacy based on his examination of the award, he may order that it be increased or decreased or order a new trial on the issue of damages if the adversely affected party does not agree with the remittitur or additur.

COMMENTARY — This new law combined with the Statute of Limitations adopted by the 1975 Session (which places a limit of two years on filing suit from the date of incidence, or two years from the date of discovery, but in no event would exceed four years); the Florida Supreme Court's unanimous decision upholding the constitutionality of pre-trial mediation panels in medical negligence suits should have a direct impact on the tort system and the cost of medical care in Florida. These laws pertaining to Professional Liability, the Supreme Court's decision upholding mediation panels, the FMA establishment of the FMA-Professional Liability Insurance Trust, and PIMCO, the Management Company, approaches a model for the nation and should provide some stability to the Professional Liability Insurance crisis in Florida.

Errata

In an article entitled "The Red Tide and Other Phytoplanktonic Thoughts" published in The Journal in June 1976, the figure on page 410 was erroneously credited to Music, Howell and Brumback (reference 2). It should have been ascribed to Steidinger and Joyce (reference 1). The figure appears on page 9 of their publication.

On page 500 of the July issue of The Journal one picture was mistakenly identified as Dr. and Mrs. Don C. Smallwood of Delray Beach. Actually, the couple is Dr. and Mrs. Victor R. Scarano of St. Petersburg. The Journal apologizes to both the Smallwoods and the Scaranos for the error.



In Memoriam
Curtis W. Cannon, M.D.

Curtis W. Cannon, M.D., one of the most courageous men that I have ever known. He loved his profession as he loved life, and although he died at the early age of fifty, his accomplishments were many and will forever be remembered by his friends, colleagues, patients, and loved ones.

Curtis truly believed in the basic principles of freedom and democracy, and devoted his time and energy to defend those freedoms that we so dearly cherish.

Curtis was a graduate of the University of Miami School of Medicine in 1956 and completed his internship and residency at Duval Medical Center in Jacksonville. He came to Palm Beach County in 1960 and established his practice of Obstetrics and Gynecology, and immediately became active in organized medicine. He served organized medicine in several capacities and became President of the Palm Beach County Medical Society in 1973. At the time of his death, Curtis was serving on the Board of Governors of the Florida Medical Association and had served for five years as Delegate to the Florida Medical Association. He was elected Alternate Delegate to the American Medical Association in 1975 and was Chief of the Department of Obstetrics and Gynecology at The Good Samaritan Hospital. Curtis was also involved in civic organizations; he was the Past President of the Northwood Kiwanis Club, the Past President of the American Cancer Society of the Palm Beach County Unit for two terms and also served on the Board of Directors of the Atlantic National West Bank in West Palm Beach.

Curtis was a man of great conviction and when there was need for someone to spearhead a cause, he was the first to volunteer his services. We shall truly miss this great man of courage.

He is survived by a daughter, Mrs. Ruby Frascatore of Burbank, California and a son, Curtis W. Cannon Jr., of West Palm Beach.

Vernon B. Astler, M.D.

Florida's Dr. Francis T. Holland Elected AMA Vice President

Francis Turner Holland, M.D., of Tallahassee, has been elected Vice President of the American Medical Association, capping a distinguished career in organized medicine bridging five decades.

Dr. Holland, a member of Florida's AMA delegation since 1955 and currently its chairman, was elected unanimously during the AMA's Annual Meeting at Dallas, Texas, last June. The one-year term will last until June of 1977, 40 years from the time he established his practice at Tallahassee.

Having decided not to seek re-election to the AMA House of Delegates, he is serving his final year in that post.

Dr. Holland's life is one replete with honors, awards and accomplishments. In 1970, he received both a Certificate of Appreciation from the American Medical Association and the Florida Medical Association's Certificate of Merit, the highest honor FMA can bestow upon a member.

In 1975, he was honored by the Florida Division of Driver Licenses at the Annual Meeting of the FMA for his 22 years of service as Chairman of the Medical Advisory Committee to the Florida Department of Highway Safety and Motor Vehicles. An orthopedic surgeon, Dr. Holland was cited earlier this year as "Visionary of the Year" by the Florida Society of Ophthalmology.

Twice President of what is now the Capital Medical Society, Dr. Holland interrupted his practice for about three and a half years during World War II for service as an Army Medical Corps officer.

He was instrumental in forming the Florida Committee on Rural Health and served as its Chairman in the 1950s. For 10 years he was a member of the AMA Council on Rural Health, rising to Chairman in 1969.

A native of Greenwood, South Carolina, Dr. Holland received his medical degree from Emory University in 1933. Professional memberships include the American College of Surgeons, World Medical Association, Southern Medical Association, Southeastern Surgical Congress, and the International College of Surgeons.

Dr. Holland and his wife, the former Sara Agnes Jackson, are the parents of four children. A son, Charles J., is associated with Dr. Holland in the practice of orthopedic surgery.



Francis T. Holland, M.D. (left), in another moment of honor; receiving American Medical Association Certificate of Appreciation from L. J. Snyder, M.D., then Chairman of the AMA Council on Rural Health. (1970 Photo).

Conference on the Identification of Needs and Standards for In-Hospital Critical Care

Arthur Trask, M.D.

Host International Hotel, Tampa
Grand Ballroom
September 11-12, 1976

During its 1976 Annual Meeting, the Florida Medical Association endorsed the basic concept of optimal care of catastrophic illness and injuries. By their action, the House of Delegates emphasized optimal care is a highly desirable goal of Florida physicians. On September 11 and 12 at the Host International Hotel in Tampa, the Committee on Emergency Medical Services will co-sponsor with the Health Program Office a multidisciplinary Conference to determine hospital capabilities. The following categories of in-hospital critical care will be considered:

1. Major trauma
2. Cardiac and general medical emergencies
3. Burns
4. Head and spinal cord injuries
5. Neonatal
6. Psychiatric, poison, drug and alcohol

Emphasis will be given to the development of a method to profile in an objective and fair manner the critical services offered by hospitals. It must be dynamic enough to respond to changes in "state of the art" and individual hospital capabilities. Such a plan of stratification should be designed specifically for the citizens of this state rather than a simple duplication that has been formulated in other parts of the country.

Conference deliberations will commence with consideration of the following questions:

1. Is there really a valid reason to have different levels of care at the present time or in the immediate future?
2. Is it medically feasible?
3. Is it economically and logistically feasible?

If the answers to these questions are in the positive, then our goal will be to outline in a simplified manner how stratification could be implemented.

It is the Committee's intent to take advantage of the state's available expertise, therefore, it is imperative all the involved medical and para-medical groups participate. We encourage representatives from county medical societies, specialty groups, allied health professions, hospital administrations, and voluntary health agencies to attend.

The Committee on Emergency Medical Services and Emergency Communications feels strongly a Conference of this type and caliber will reflect in a positive way the concern of Florida physicians for providing the best possible medical care for the citizens of our state.

Dr. Trask is Chairman, FMA Committee on Emergency Medical Services and Emergency Communications.

AGENDA

Conference on Identification of Needs and Standards for In-Hospital Critical Care

Saturday, September 11

9:00 a.m.—Introduction
Arthur Trask, M.D., Chairman of Committee on Emergency Medical Services and Emergency Communications

9:15 —Welcome and Opening Remarks
Jack A. MaCris, M.D., President
Florida Medical Association

9:30 —Purposes and Objectives of the Conference
Arthur Trask, M.D.
Henry C. Huntley, M.D., Administrator, EMS Section Health Program Office, Department HRS

9:45 —Keynote Address
Jay M. Kranz, M.D., F.A.C.P., Washington State, Chairman, Committee on Trauma, American College of Surgeons

10:15 —Coffee Break

10:30 —Legal Aspects
Frank J. McCowan, Jr., Esq.

11:00 —WORKSHOPS (Closed Session—Restricted to Panel Members)

12:00 p.m.—Lunch

1:30 —WORKSHOPS (Open to All)
1. Major Trauma
2. Cardiac and general medical emergencies
3. Burns
4. Head and spinal cord injuries
5. Neonatal
6. Psychiatric, poison, drug and alcohol

4:00 —Coffee Break

4:15 —WORKSHOPS (Closed Session—Restricted to Panel Members)

Sunday, September 12

9:30 a.m.—Call to Order
General Meeting (Open to All)
Workshop Reports presented by Chairmen

11:00 —Conference Summary
David O. Westmark, M.D., FMA Committee on Emergency Medical Services and Emergency Communications

Copy of Telegram Sent 5-24-76

D. L. Armstrong
Southern Bell
250 Alhambra Circle
Room 336
Coral Gables, Florida

Southern Bell was notified by the Florida Medical Association on March 4, 1976 as to the approved ethical telephone directory specialty and sub-specialty headings for members of the FMA, and its component county medical societies.

The previously announced policy of the FMA is applicable to all of its component medical societies and the 10,500 physicians who are members jointly of these component county medical societies and/or one of recognized specialty groups. Component county medical societies of the FMA are chartered by the FMA and may not operate in conflict with established policy of the FMA. Failure of a component county medical society or any member to adhere to established ethical policies of the FMA could result in loss of charter by said society or membership by a physician.

We strongly urge Southern Bell not to be a party to any improper activities with references to listings by physicians in your directory.

To ensure that you may cooperate with the established policy of the FMA on this issue, we are sending you by certified mail the approved specialty and sub-specialty headings. These are the only listings that may be ethically listed in your directory for members of the FMA.

John E. Thrasher
Legal Counsel
Florida Medical Association, Inc.

MEMORANDUM*

TO: Presidents and Secretaries, Component Medical Societies
Presidents and Secretaries, FMA-Recognized Specialty Groups Members, Council on Specialty Medicine
Southern Bell
General Telephone
Independent Telephone Companies

*Second memorandum, the first was dated March 4, 1976.

FROM: W. Harold Parham, D.H.A., Exec. V.P.
SUBJECT: Telephone Directory Specialty Headings

On February 1, 1976, the House of Delegates adopted the following policy on "Telephone Directory Specialty Headings" for members of the FMA:

> "Only those specialties and sub-specialties which have certifying boards and which boards are recognized by the American Medical Association may be used for listings in the specialty section of the telephone directory yellow pages."

An alphabetical list of those specialties and sub-specialties approved for telephone directory listings are

TELEPHONE DIRECTORY SPECIALTY HEADINGS FOR MEMBERS OF THE FMA

"Only those specialties and sub-specialties which have certifying boards and which boards are recognized by the American Medical Association may be used for listings in the specialty section of the telephone directory yellow pages."

1. Aerospace Medicine
2. Allergy and Immunology
3. Anatomic and Clinical Pathology
4. Anatomic Pathology
5. Anesthesiology
6. Blood Banking
7. Cardiovascular Disease
8. Child Neurology
9. Child Psychiatry
10. Clinical Pathology
11. Chemical Pathology
12. Colon and Rectal Surgery
13. Dermatology
14. Dermatopathology
15. Diagnostic Radiological Physics
16. Diagnostic Radiology
17. Endocrinology and Metabolism
18. Family Practice
19. Forensic Pathology
20. Gastroenterology
21. General Preventive Medicine
22. Gynecologic Oncology
23. Hematology
24. Infectious Disease
25. Internal Medicine
26. Maternal and Fetal Medicine
27. Medical Microbiology
28. Medical Nuclear Physics
29. Medical Oncology
30. Neonatal-Perinatal Medicine
31. Nephrology
32. Neurological Surgery

33. Neurology
34. Neuropathology
35. Nuclear Medicine
36. Nuclear Radiology
37. Obstetrics and Gynecology
38. Occupational Medicine
39. Ophthalmology
40. Orthopedic Surgery
41. Otolaryngology
42. Pathology
43. Pediatrics
44. Pediatric Cardiology
45. Pediatric Hematology-Oncology
46. Pediatric Nephrology
47. Pediatric Surgery
48. Physical Medicine & Rehabilitation
49. Plastic Surgery
50. Psychiatry
51. Psychiatry and Neurology
52. Public Health
53. Pulmonary Disease
54. Radiologic Physics
55. Radioisotopic Pathology
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61. Therapeutic Radiology
62. Thoracic Surgery
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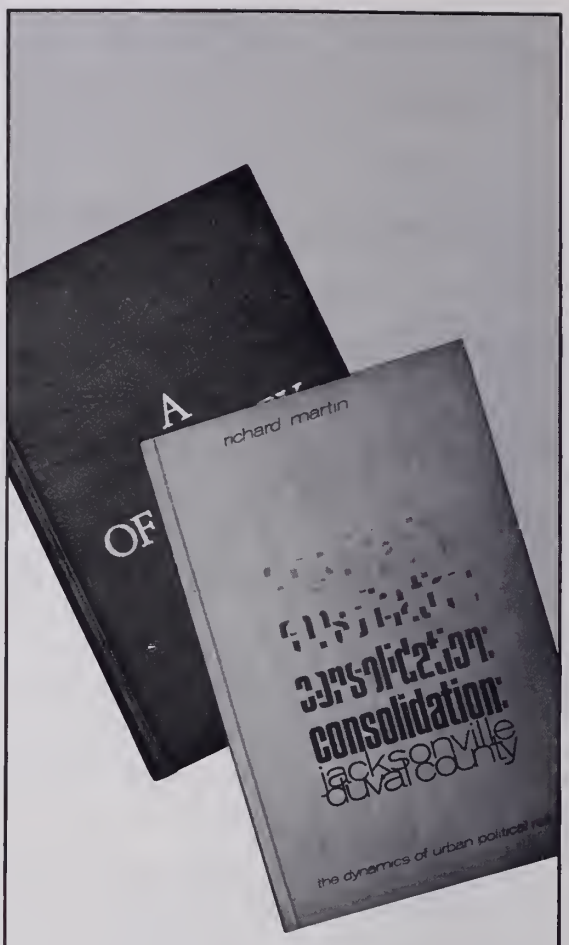
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UNIVERSITY OF MIAMI SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE
THIRD ANNUAL REVIEW COURSE
"Fundamental and Clinical Aspects of Internal Medicine"

KEY BISCAYNE HOTEL — **OCTOBER 10-23, 1976** — **KEY BISCAYNE, (MIAMI) FLORIDA**

Directors: William J. Harrington, M.D., Eric Reiss, M.D., and Neal S. Bricker, M.D.
Program Coordinator: Jose S. Bocles, M.D.

This course is designed primarily for internists who are preparing for certifying examinations. It is intended to provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Each subspecialty will be reviewed as described under "Schedule." Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Printed texts and references will be provided to all registrants, and audio-visual teaching aids will be available for self-instruction and reinforcement.

SCHEDULE

WEEK I—October 11-16, 1976

October	11	Pulmonary Diseases
"	12	Nephrology
"	13	Hypertension & Acid Base Disorders
"	14	Infectious Diseases & Immunology
"	15	Hematology
"	16	Oncology & Genetics

WEEK II—October 18-23, 1976

October	18	Rheumatology
"	19	Cardiology
"	20	Neurology & Psychiatry
"	21	Endocrinology & Metabolism
"	22	Clinical Pharmacology, Dermatology Toxicology & Environmental Medicine
"	23	Gastroenterology & Hepatology

LECTURES
The course will consist of daily sessions, Monday through Saturday for two successive weeks. On each day beginning at 8:00 a.m., fundamental and core material on a given topic will be presented. After a coffee break (10.00-10:30 a.m.), recent advances will be reviewed from 10:30 a.m. to 12:30 p.m. and from 5:00 to 7:00 p.m.

LEARNING CENTER
Fully automatic synchronized cassette/slide sound projection of lectures.

MEET THE FACULTY SESSIONS
Will be held every day from 3:00 to 4:30 p.m. and will consist of simultaneous small group conferences in which illustrated aspects of each subspecialty will be presented, followed by open discussions and topics not formally reviewed in the lectures.

SELF-TEACHING AUDIOVISUAL AIDS
Television sets with tape players and slide review projectors with cassette tapes will be available throughout the entire meeting.

This course is accredited on an hour by hour basis (90 hours-Category I) toward the AMA's Physician's Recognition Award and the Florida Medical Association, Category A.

REGISTRATION FEES:

Entire Course (Oct. 11-23)	$500
Week I (Oct. 11-16)	$300
Week II (Oct. 18-23)	$300
Per day (minimum of 3 days)	$ 70

Checks payable to: U/MIAMI INTERNAL MEDICINE REVIEW COURSE

LIMITED REGISTRATION—REGISTER EARLY

For information and application write to:

J. BOCLES, M.D.
Department of Medicine
University of Miami School of Medicine
P.O. Box 520875, Biscayne Annex
Miami, Florida 33152
Phone: 305/547-6063

Commentary

The following letter, widely distributed to major newspapers around the country, by Ward Wagner Jr., President, Association of Trial Lawyers of America, is being published to clarify Dr. Astler's response on behalf of the Association.

THERE HAS never been a time when democracy has seen so severe a test of its basic institutions. Fundamental rights are under attack. The medical profession for its own financial gain, spending huge numbers of hours of its members' time and money in astronomical amounts, is lobbying for virtual immunity from the consequences of its own negligent acts.

The medical profession's acts are twofold. First comes the negligent act causing the injury compensable in a medical negligence case. Second the arbitrary, capricious, arrogant act of seeing such negligent acts and yet ignoring them and not making a genuine and sincere effort to clean its own house. If the profession would put the members' time and money and dedication into cleaning its own house that it is putting into lobbying for a special place in the law in derogation of the rights of the people, the cost of the malpractice premiums would fall as a consequence of a greatly diminished incidence of injury caused by medical negligence.

The medical profession comes to the legislature for a handout with unclean hands. What is their demonstrated response to the law passed by the legislature last year which gave them more power than ever before to regulate quality into the medical practice? None.

There is no reason for legislation in the malpractice area this year. It should await the results of the medical profession's use of the law passed giving them tools and teeth for the housecleaning so badly needed.

Let's now look at another severe test of democracy, basic institutions and fundamental rights. The Florida Legislature was sold a no-fault auto bill of goods several years ago. The legislature was sold that bill of goods by insurance companies who promised cheaper insurance and bludgeoned to pass it by newspaper editorials and articles supporting it and leader prophets who also promised cheaper insurance. Now a new legislature some years later, with a number of key holdovers, is reconsidering the law passed by the cheaper insurance, newspaper bludgeoned, leader prophets. People who fail to remember what has happened in the past make the same mistakes again.

Take a look at what has occurred in the real world. The insurance companies who promised cheaper insurance in return for the confiscation of rights of some injured people lied. The insurance costs have risen substantially. The newspapers who daily during the legislative session bludgeoned legislative leader prophets who led the fight to pass the legislation on the promise (sold them by the insurance industry) that this would bring cheaper insurance and took rights from the people have proved to be false prophets.

Will our elected representatives prove they cannot learn by history?

There is one successful no-fault law. That one is history. It is the Oregon Plan. It does not take away rights of the people. The legislature should pass it as it has substantiated, documented success in the real world. And in a country where we pride ourselves on expanding human and fundamental rights, I hope I can believe that the press will not tolerate elimination of fundamental rights any more than it would if we were discussing freedom of the press. To snuff out one candle of rights is to begin subversion and abrogation of all others.

Mr. Raymond J. Mariotti
Editor
Palm Beach Post
2751 South Dixie
West Palm Beach, Florida

Dear Mr. Mariotti: This is a reply to the letter to the Editor in your publication from Monday, May 10, 1976, entitled "False Profits" and written by Mr. Ward Wagner, Jr., President of the Association of Trial Lawyers of America.

Dear Sir:

I cannot allow such blatantly false letters to go unanswered as Mr. Wagner continues to pontificate.

Item 1—erroneous information was released by spokesmen for the trial lawyers regarding the physician assessment. Actually, the physicians of the Florida Medical Association did in January, 1976, assess themselves $100 each for a 5-year program to establish better public relations and to retain necessary legal counsel, lobbyists, statisticians, etc., to allow our story to be told. To date, nowhere near this amount has been received or spent.

Item 2—Mr. Wagner next relates the negligence act as "step one" in the process. I should hardly need to point out that the great majority of cases predetermined by lawyers for the plaintiff (such as Mr. Wagner) to exhibit negligence by the physician are adjudicated to the contrary under our tort system. This would indicate the high percentage of spurious or nuisance suits. A recent study in Cali-

fornia covering 15 years revealed 252 million dollars went to plaintiffs' attorneys and 126 million dollars to defense attorneys.

Item 3—Mr. Wagner neglected to mention the amount paid to the injured party in various studies —New York—25-40 cents of the premium dollar goes to the injured; Michigan—25 cents of the premium dollar goes to the injured; national estimate of the Commission appointed by the Secretary of HEW revealed 16-38 cents of the premium dollar actually goes to the plaintiff; the Insurance Service Organization (ISO) in a study revealed 87 percent of claim expense dollars go to the legal community. No wonder insurance costs have risen substantially.

Item 4—Mr. Wagner charges the doctors of Florida with not "cleaning their house." A recent review in Florida showed the Florida State Board of Medical Examiners restricted or removed the license to practice from 233 physicians from the period 1969 to 1975. During a similar period, the Florida Bar took actions to restrict or remove from practice 211 attorneys, despite the fact that there are almost two attorneys for every physician practicing in Florida.

Item 5—Mr. Wagner uses the old ploy accusing the insurance companies of reaping the profits. Our FMA figures from the Employers Group revealed that they left the state with a 24 million dollar loss after an experience of approximately ten years in Florida. Common sense would dictate that insurance companies have little reason to run away from the windfall profits Mr. Wagner alleges, yet last year virtually no private insurance market existed in Florida. This situation necessitated the creation by the Florida Legislature of the Joint Underwriting Association (JUA) to allow coverage for doctors to protect the party who is truly harmed through professional negligence.

Item 6—Actuarial projections indicate a continuing increase in the number of suits and the amounts of settlements and judgments. A greater increase in these numbers has been seen in the states where "no fault" auto insurance has been tried, possibly indicating a necessary redirecting of the legal marketplace.

Item 7—Mr. Wagner fails to mention the contingency fee and the "referral fee system" which is still common place among his profession. The medical profession condemned and virtually wiped out this practice many years ago. The United States is the only major nation with a contingency fee system and the only one with a serious medical liability crisis. In Canada, where the contingency fee is not a major factor, the liability insurance premium for doctors approximates $200 per year. United States doctors pay up to 50 times that amount and do not seem to me to be 50 times less competent than their Canadian counterparts.

Vernon B. Astler, M.D.
Immediate Past President
Florida Medical Association

Dear Doctor Astler: Your **President's Page** in April, 1976 **Journal of the Florida Medical Association** was the best I have seen during my twenty years as a member of FMA.

During the time I was in private practice of surgery I was constantly in awe of the massive amounts of money I was spending on behalf of my patients. During that time I did constantly remind myself that I should not order anything for one of my patients that I would not order if I were actually having to pay cash for the item out of my own pocket. I am sure this attitude saved my patients hundreds of thousands of dollars during the eight years I was in practice.

Since having come with the state, I have become extremely aware of the cost of unnecessary laboratory or x-ray procedures. I frequently see physicians order a battery of tests on one of our clients in a shotgun fashion when, in fact, a specific single test would often be sufficient.

If every physician in the state would follow your excellent recommendations, I believe we, as a profession, could make a significant contribution toward controlling and possibly even lowering the cost of medical care without in any way reducing the quality of care patients in Florida are receiving.

I would like to recommend that your special state committee take these matters under consideration and make necessary recommendations to include a physician from the Department of Health and Rehabilitative Services of Florida. Although I am, in general, opposed to the current fad of putting "consumers" on every conceivable committee, I do believe having a physician from the Department of Health and Rehabilitative Services on this committee could be useful to the committee and could help enhance the cooperation between the Florida Medical Association and DHRS.

Congratulations again on your outstanding **President's Page.**

Al Ogden, M.D.
HRS Vocational Rehabilitation
State Medical Consultant
Tallahassee

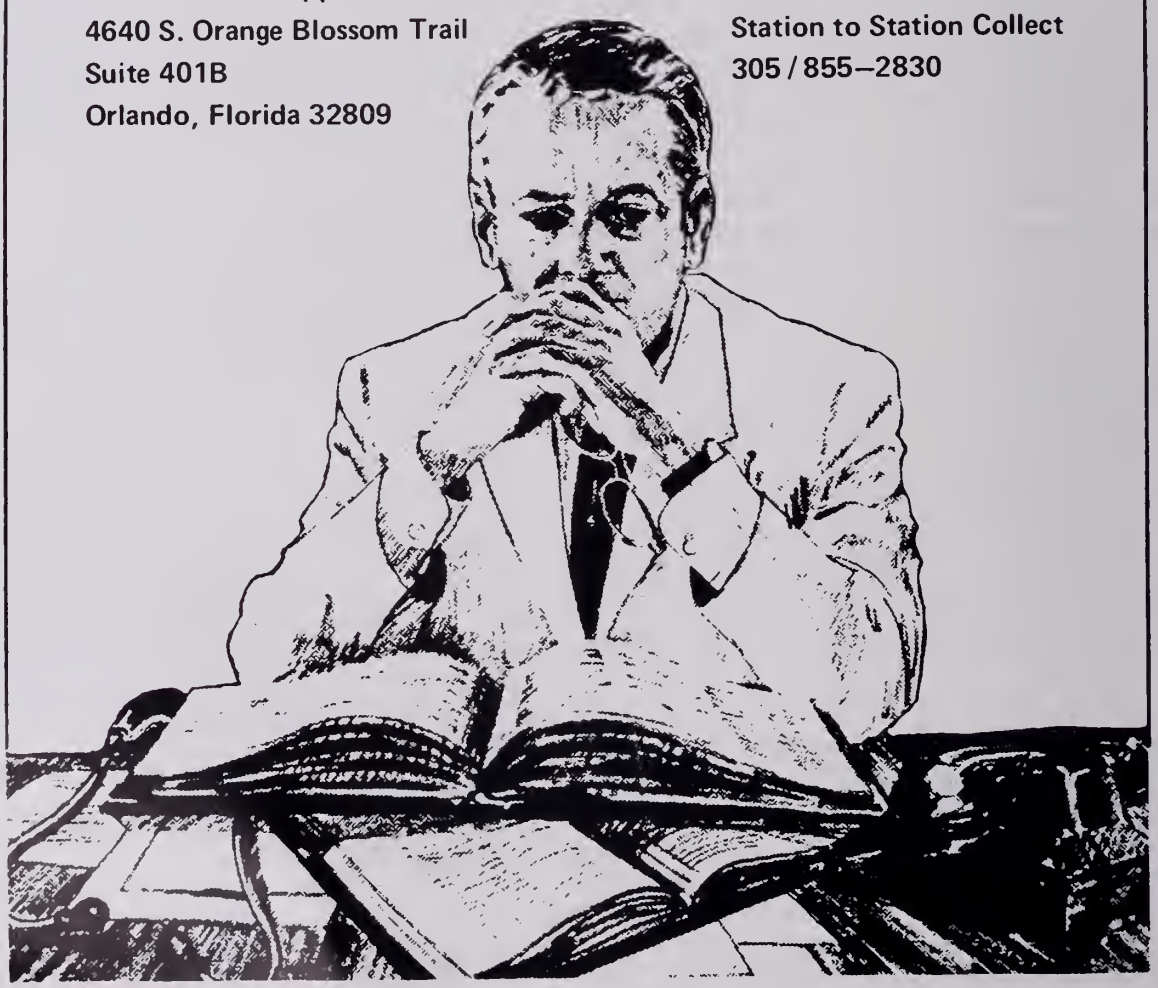
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ACCREDITED BY THE J. C. A. H.

Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

Inflammatory Bowel Disease, edited by Joseph B. Kirsner, M.D., Ph.D. and Roy G. Shorter, M.D. 465 Pages. 240 illustrations, 20 in color. Price $35.00. Lea & Febiger, Philadelphia, Pa., 1975.

This is an excellent, all encompassing monograph on inflammatory bowel disease written by outstanding clinicians for clinicians. The expert on this subject, senior editor, Dr. Kirsner, is world-wide recognized. All clinical aspects of the disease within the intestinal tract and the extra-intestinal manifestations are thoroughly reviewed. There is excellent illustrative material throughout, with color photographs being particularly impressive where they are truly needed. An example of this is in the particularly valuable color photographs of the dermatological complications. The roentgen manifestations are contributed in a chapter by Dr. Richard Marshak, whose outstanding x-ray illustrations, and there are many of them, add immeasurably to comprehension of the chapter. Certain chapters are more sophisticated for the students doing clinical research in this disease or wanting a more thorough explanation of certain clinically related basic information. An example of this is the chapter on cell mediated immune responses, but these chapters can also be understood by a clinician who desires the information if they are read slowly and deliberately.

The approach to therapy is very realistic and complete. As an example, Kirsner and Wall, in the discussion of the medical treatment, emphasize that there is no specific or curative therapy. Medical therapy remains asymptomatic.

Special chapters are dedicated to the problems in the pediatric age group with these syndromes. In addition, there are chapters with practical aspects in the care of ileostomy and colostomy.

All in all, this is a complete treatise on inflammatory bowel disease and can be of help to any physician who comes in contact with these disorders.

Martin H. Kalser, M.D.
Miami

Dr. Kalser is Professor of Medicine and Chief, Division of Gastroenterology, University of Miami School of Medicine, Miami.

Tracheal Intubation by Edward L. Applebaum, M.D., F.A.C.S. and David L. Bruce, M.D. Illustrated. 97 Pages. Price $9.95. W. B. Saunders Company, Philadelphia, 1976.

Applebaum and Bruce have done a remarkable job consolidating the subject of tracheal intubation into a single text. The authors state in their preface that "there has been no single reference which may be consulted by those involved in airway care." This book has been written with a variety of readers in mind. It can be effectively utilized by the physician, nursing staff, respiratory therapists, and emergency paramedic personnel. Consequently, although a technical work, it is written in easily understood terminology.

The book is divided into eight chapters covering such topics as Indications for Intubation, Techniques of Tracheal Intubation, Complications of Tracheal Intubation, and an excellent chapter on Anatomy of the Respiratory Passages. The chapters are subdivided with headings for key topics and tables for quick reference. Each chapter is complete with a list of references and the book is well indexed.

Each major technique or topic is illustrated by photograph, Xeroradiograph, drawing, or various combinations of illustrations demonstrating several views. The fine drawings, including the front cover, were done by Jennifer Giancarlo.

Michael W. Popejoy
Orlando

Mr. Popejoy is a student at Florida Technology University working on a degree in Zoology and will continue for a Doctorate in Neurophysiology at the University of South Florida.

He who can not forgive others
Breaks the bridge over which
He must pass himself.

George Herbert

Infectious Diseases in Obstetrics and Gynecology by Gilles R. G. Monif, M.D. 458 Pages. $27.50. Harper & Row, Publishers, Inc., Hagerstown, Md., 1975.

There has been a long need for a compendium concerning infectious diseases in the specialty of Obstetrics and Gynecology. Heretofore information on this subject has been scattered and Dr. Monif is to be commended for his effort in consolidating the concept of infectious illness observed in the obstetric and gynecologic patient. Since most infectious agents can affect the female patient and since some of these infections are unique to pregnancy, there is a special need for such a book for those interested in the health care of women. In this volume Dr. Monif and his 15 contributors have approached the concept of infectious disease by providing a ready reference source in an orderly fashion.

Early chapters of the text are concerned with brief descriptions of the nature of infectious agents and of antimicrobial agents utilized to combat these infectious organisms. I found the charts classifying antimicrobial agents and their mechanisms of action to be particularly useful and these charts are probably well worth the price of the book. The section concerning viruses is brief, lucid and specific mechanisms of viral transfer are clearly outlined. Some detail is given to the description of cytomegalic virus illnesses, herpes homonomous infections, hepatitis, rubella and varicella zoster infections. There are sound suggestions for clinical management of these patients.

Further discussion is given to mycoplasma infections, venereal diseases, protozoan infections. microbacterial infections and fungus infections.

A section considers in detail post abortal infections, septic pelvic thrombophlebitis, chorioamnionitis and recommendations are made concerning their management. We were particularly gratified to note that the routine use of "prophylactic antibiotics" is condemned. One chapter is devoted to hospital acquired infections, particularly those associated with the routine instrumentation of both the obstetrical and gynecologic patient. Considerable detail is given to the discussion of the various portals of entry via tracheal intubation, urinary tract catheterization, intravenous catheterization and good points were made concerning the dangers of routine postoperative pulmonary ventilatory therapy.

A much needed section is devoted to vaccination in pregnancy. This chapter clarifies the difference between "live" and "killed" virus vaccines and the indications for their use.

The section treating pneumonia during pregnancy is interesting and the discussion of the vulvovaginitides is good. The chapter devoted to pelvic inflammatory disease and sequelae is timely.

The discussion of postoperative infections could have been more detailed. Postoperative febrile morbidity is certainly one of the most distressing problems following pelvic surgery, particularly colpoplastic repair and vaginal hysterectomy, and it would appear that greater emphasis should have been placed on meticulous hemostasis, adequate wound drainage and antibiotic therapy, but generally speaking, the chapter is satisfactory.

Proper emphasis is placed on the anaerobic organisms as infectious agents and special emphasis is placed on the unique virulence of the anaerobic streptococci and Bacteroides species.

This text presents an orderly approach to the nature of obstetric and gynecologic infections and establishes clear clinical guides for their treatment.

This book definitely fills a gap in spite of its shortcomings and should be available for immediate reference to all of those treating the obstetric and gynecologic patient.

J. B. Williams Jr., M.D.
Jacksonville

Dr. Williams is a practicing Obstetrician-Gynecologist in Jacksonville.

New Organization for Foreign Medical Graduates Schedules Convention

The newly organized American College of International Physicians will conduct its first Annual Convention, Scientific Session and Convocation of Fellows in Chicago, October 16-17.

Composed of licensed physicians who are graduates of foreign medical schools, the College was recently incorporated as a nonprofit, tax-exempt organization. Officers were elected at an organizational meeting last September in Indianapolis. Antonio B. Donesa, M.D., of Fort Wayne, Ind., a graduate of the University of the Philippines, was chosen as the first President.

Information and membership applications may be obtained by contacting Dr. Donesa at the College offices, Suite 12, 3030 Lake Avenue, Fort Wayne, Ind. 46805.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.-O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

Principles of Clinical Electrocardiography, 9th Edition by Mervin J. Goldman, M.D. 412 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1976.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

The New Way to Live With Diabetes by Brian Boylan and Charles Weller, M.D. 140 Pages. Price $2.50 (paperback). Doubleday & Company, Inc., New York, 1976.

The Woman Alcoholic by Vera Lindbeck. 28 Pages. Price 35¢. New York, Public Affairs Pamphlets, 1975.

Focus on Care of the Elderly by Donald F. Phillips et al. 114 Pages. Price $4.75. Contemporary Publishing, Inc. Wakefield, Massachusetts, 1975.

Preparation for Parenthood Through Group Discussion by Aline B. Auerbach. 57 pages. Available on request from Educational Services, Patient Care Division, Johnson & Johnson, New Brunswick, N. J. 08903.

This book by a parent group consultant is subtitled, "A Guide For Nurse-Leader of Expectant-Parent Classes". This guide includes chapters on organization of expectant parent discussion groups, basic requirements for leadership, as well as techniques of group discussion and suggested curriculum. It includes a bibliography for suggested reading.

Review of Medical Microbiology, 12th Edition, by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. 542 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price $15.00. Los Altos, California, Lange Medical Publications, 1976.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus,** volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publications should be designated "For Publication."

NORTH FLORIDA REGIONAL HOSPITAL

and

THE NORTH FLORIDA REGIONAL MEDICAL FOUNDATION

Announce

"THE THIRD ANNUAL CARDIOVASCULAR SYMPOSIUM"

SEPTEMBER 9-10, 1976

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Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

This symposium is designed to review and explore the diagnostic procedures and therapeutic modalities that are available for the detection and treatment of cardiovascular disease. A special evening session is devoted to the use and value of echocardiography. An outstanding faculty has been assembled for the symposium and the program should be of interest to all physicians taking care of patients with cardiac disease.

FACULTY

CHRISTIAN BARNARD, M.D.	MICHAEL DeBAKEY, M.D.	RENE FAVALORO, M.D.
RICHARD GORLIN, M.D.	ALBERT STARR, M.D.	F. MASON SONES, M.D.
CHARLES RACKLEY, M.D.	BRUCE LOGUE, M.D.	WILL C. SEALY, M.D.
RICHARD L. POPP, M.D.	MICHAEL JOHNSON, M.D.	JOHN H. LARAGH, M.D.
THOMAS B. FERGUSON, M.D.	JOSEPH W. LINHART, M.D.	SPENCER B. KING, III, M.D.

(Approval for credit for CE units has been requested from the AAFP, FMA, AACN and FNA.)

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Hotel, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton Inn direct, (904) 377-4000.

RESERVATION FEES: $150. — all physicians
50. — paramedical personnel (nurses, technicians, etc.)

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Program Director
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REGISTRATION IS LIMITED — REGISTER EARLY

(Fees will be refunded for cancellations received no later than August 27th.) For further information write to: Howard W. Ramsey, M.D., at the above address.



Dr. **Robert E. Windom,** FMA Secretary from Sarasota, has formally announced his candidacy for a seat in the Florida House of Representatives. He will run for the seat in District 74, recently vacated by Rep. Robert M. Johnson of Sarasota.

At the annual meeting of the Florida Medical Association, three of Florida's eminent orthopedic surgeons were given honorary membership in the Florida Pediatric Society. They were Drs. **Robert P. Keiser** of Miami; **Philip Lichtblau** of Palm Beach, and **Joseph Matthews** of Orlando, an Assistant Editor of the FMA Journal.

The presentations were made by Dr. **W. Reed Bell,** President of the Florida Pediatric Society, in recognition of their decades of service to handicapped children.

James R. Forlaw, M.D. . . . a family physician from Boynton Beach, has been appointed to the FMA Board of Governors, succeeding the late Curtis W. Cannon, M.D., of West Palm Beach.

A native of Jacksonville, Dr. Forlaw will fill the at-large seat on the Board for a one-year term. He attended Emory University and received his M.D. degree in 1956 from the University of Miami School of Medicine.

Dr. Forlaw has served on several FMA committees and is currently the Chairman of the Council on Medical Services.

Two Florida physicians and a medical student . . . all associated with medical school pediatric departments, have been awarded Southern Medical Association research grants. They are among 25 researchers selected from more than 100 applicants to receive grants this year.

Florida recipients are:

—**John I. Malone, M.D.,** Department of Pediatrics, University of South Florida College of Medicine, Tampa, for "The Incidence and Natural History of Diabetic Retinopathy in Children."

—**Jeane A. McCarthy, M.D.,** Department of Pediatrics, University of Miami School of Medicine, Miami, for "Prenatal Sensitization of Rh Negative Infants Born to Rh Positive Mothers."

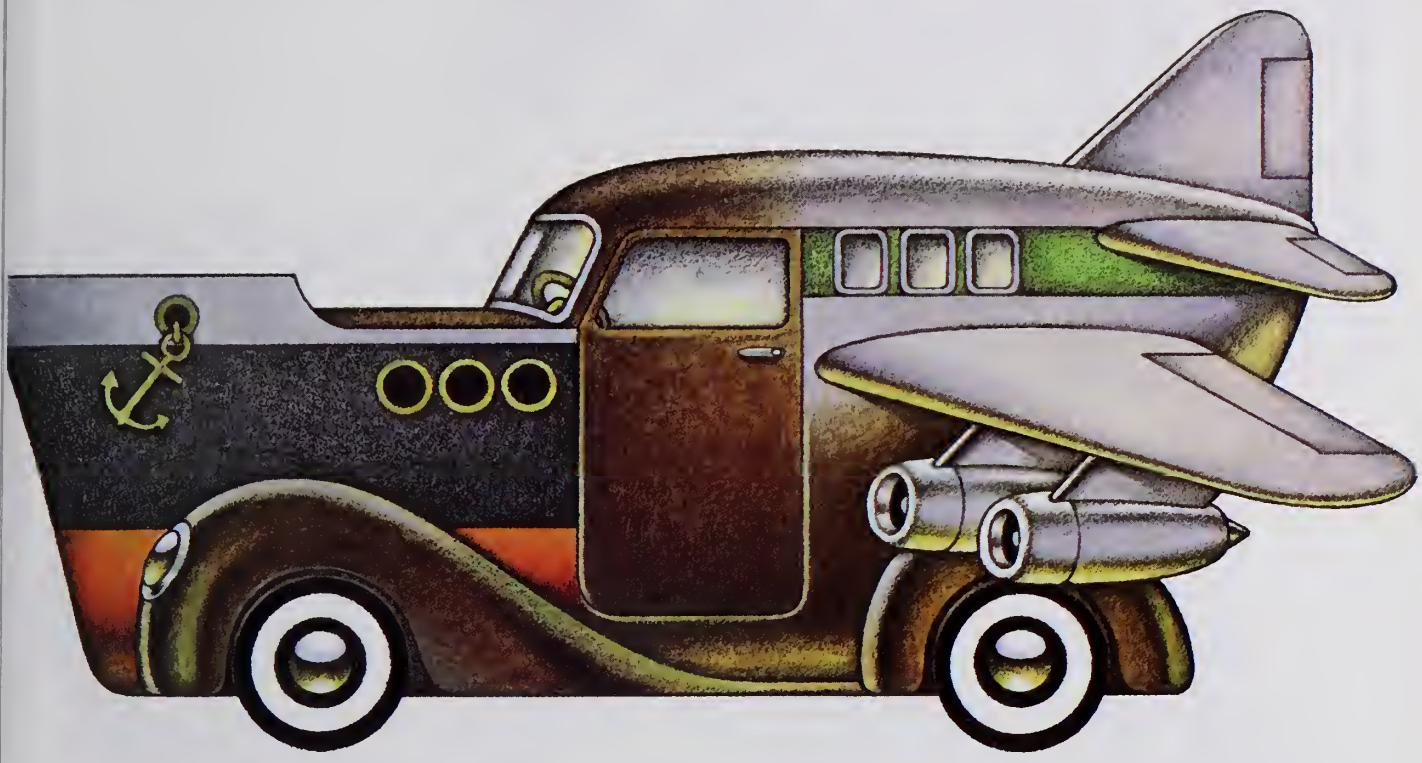
David E. Yocum, Fourth-year medical student at the University of Florida College of Medicine, Gainesville, for "Macrophage Phagocytosis Index as a Measure of Cellular Immunity in Childhood Leukemia."

Mr. Michael H. Lopez Jr., Executive Vice President of the Palm Beach County Medical Society has announced his candidacy for a seat in the House of Representatives.

Physicians and attorneys attended a social function in the "spirit of detente" at the home of **Dr. and Mrs. Ernest Wollin** in Leesburg. Invitations were extended jointly by the Board of Governors of the Lake County Medical Society and the Board of Trustees of the Lake County Bar Association to all members of each group. Approximately 170 attended the event. Dan Robuck, right, President of the Lake County Bar Association, is greeted by Dr. and Mrs. Wollin. Dr. Wollin is President of the Lake County Medical Society. Extending the spirit of detente, Mrs. Wollin graduated from the University of Florida College of Law in June.



Dr. and Mrs. Wollin greet Mr. Robuck.



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The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

ROERIG Pfizer
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New York, New York 10017

Antivert®/25 Chewable Tablets
(meclizine HCl) 25 mg.
for motion sickness

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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WHEN ANXIETY INTERFERES.

The cardiac patient and anxiety.



"The [cardiac] patient is anxious about minor symptoms, about the implications of his diagnosis, and about real or imagined limitations of function."*

The worst is over. The cardiac patient is out of the acute stage, out of the hospital, and well on his way to recovery. How quickly he comes back to near normal functioning may depend on his psychological as well as his physical rehabilitation.

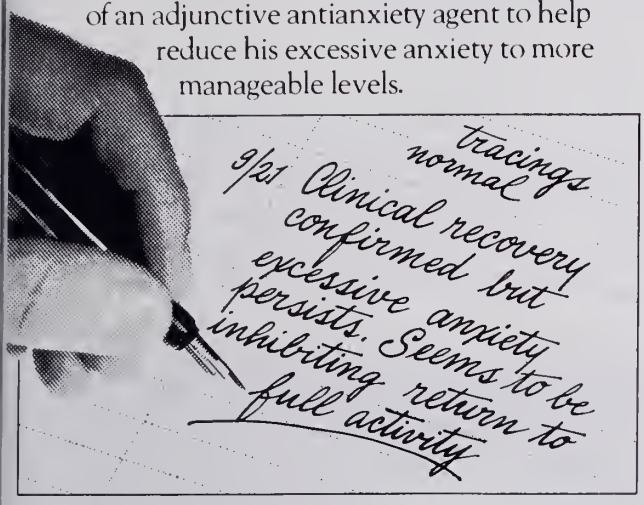
Clinical anxiety, for example, may be one reason for prolonged recuperation following cardiac healing. Yet anxiety can sometimes be beneficial in facilitating patient compliance.

The patient who is realistically concerned about resuming his precoronary functioning may be highly motivated to adhere to his rehabilitation regimen. However, the cardiac patient with *excessive* or unresolved anxiety may be so fearful of future heart failure that he refrains from your prescribed regimen. These excessively anxious cardiac patients eventually present the same clinical characteristics as patients deconditioned by bed rest

Excessive anxiety can interfere with patient management

When excessive anxiety diminishes your

patient's ability to participate fully in his rehabilitation program, your counseling and reassurance are often sufficient. But when his anxiety is so great that it actually interferes with his ability to listen and respond, you may want to consider the addition of an adjunctive antianxiety agent to help reduce his excessive anxiety to more manageable levels.



Librium® (chlordiazepoxide HCl) an effective adjunct to your reassurance and counseling

Safety: Librium has a highly favorable benefits-to-risk ratio and a wide margin of safety. Because of its low incidence of side effects, it is regarded as one of the safest antianxiety agents available. And Librium does not adversely affect the cardiovascular system. See complete product information for warnings, precautions and adverse reactions.

Performance: Hundreds of clinical trials, thousands of published papers, and millions of patients comprise the record of performance for Librium.

Concomitant use: Of special significance in treating the cardiac patient already taking multiple agents is the fact that Librium is used concomitantly with most primary medications, such as cardiac glycosides, diuretics and antihypertensives.

*Zohman BL: *Geriatrics* 28:110-119, Feb 1973

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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THE ANXIETY-SPECIFIC

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS



Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

THERAPEUTIC FOCUS ON

CAPSULES, 25 mg and 50 mg

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INDOMETHACIN | MSD)

helps relieve pain and other symptoms of inflammation in acute gouty arthritis in selected patients

INDOCIN is a potent drug with anti-inflammatory, antipyretic, and analgesic properties. It should not be used in conditions other than those recommended. Although INDOCIN does not alter the progressive course of the underlying disease, in selected patients with acute gouty arthritis it has been found highly effective in relieving pain and in reducing fever, swelling, and tenderness.

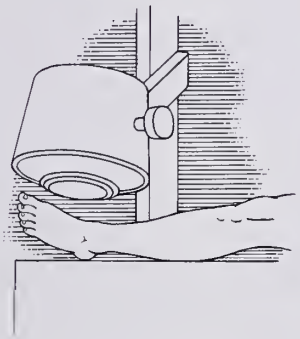
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For a brief summary of prescribing information, please see following page.

addendum

MSD
MERCK SHARP & DOHME

Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

INDOCIN®
(INDOMETHACIN | MSD)



helps relieve pain and other symptoms of inflammation in acute gouty arthritis in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day without corresponding clinical benefits; 2) careful instructions to, and observation of, the individual patient are essential to the prevention of serious and irreversible including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Drug Interactions: Although INDOCIN has not influenced the hypoprothrombinemia produced by anticoagulants, patients on anticoagulant therapy should be observed closely for alterations in prothrombin time. In patients receiving probenecid, plasma levels of indomethacin are likely to be increased and a lower total daily dose of INDOCIN may produce a therapeutic effect; increases in the dose of INDOCIN should be made cautiously and in small increments.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura may occur rarely. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, a rapid fall in blood pressure resembling a shock-like state, angioedema, dyspnea, asthma, angiitis, pruritus, urticaria, skin rashes, purpura.

Ear Reactions: Hearing disturbances—deafness reported rarely; tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD MERCK SHARP & DOHME

MEETINGS

Approved by FMA Committee on Continuing Medical Education

AUGUST

1976 Postgraduate Obstetric Pediatric Seminar, Aug. 10-12, Konover Hotel, Miami Beach. For information: Jorge Deju, M.D., Box 210, Jacksonville 32201

SEPTEMBER

Pediatric Pulmonary Disease, September 3-4, Sacred Heart Children's Hospital Auditorium, Pensacola. For information: Reed Bell, M.D., 5151 North 9th Avenue, Pensacola 32504.

Clinical Electrophysiology, Sept. 15-17, Wolfson Auditorium, Mount Sinai Hospital, Miami Beach. For information: CME Coordinator, Mount Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

Twenty Fourth Annual Diabetes Seminar, Sept. 17-19, Jacksonville. For information: Robert Miller, M.D., 1545 San Marco Blvd., Jacksonville 32207.

When Should I Get Neurologic Consultation? September 24-25, Galatea Inn, Pensacola Beach. For information: R. Douglas Collins, M.D., 1000 West Moreno Street, Pensacola 32501.

Trauma Systems and Management, A National Symposium, September 24-26, Innisbrook Resort, Tarpon Springs. For information: Lamar Crevasse, M.D., Box J-233, JHM Health Center, Gainesville 32610.

Consultations in Hypertension, September 29, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

OCTOBER

First Annual Reunion, University of Miami, Department of Family Medicine, Oct. 3-5, Americana Hotel, Miami Beach*

Obstetric/Gynecology Review Course, Oct. 2-10, Miami*

Topics in Family Medicine 1976, Oct. 6-10, University of Miami School of Medicine, Department of Family Medicine*

Review Course on **"Fundamental and Clinical Aspects of Internal Medicine,** Oct. 10-23, Key Biscayne Hotel, Miami*

17th Workshop in Electrocardiography for Cardiac Nurses & Interested Physicians, Oct. 14-18, Tides Hotel, Redington Beach, St. Petersburg. For Information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

25th Basic Colposcopy Course, Oct. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Charles B. Slack, Inc., 6900 Grove Rd., Thorofare, N.J. 08086

Second Pan American Seminar, October 18-22, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel, Key Biscayne.*

FSIM/ACP Joint Fall Meeting 1976, Oct. 22-24, Marco Beach Hotel and Villas, Marco Island. For information: Florida Society of Internal Medicine, 515 Lomax St., Jacksonville 32204

NOVEMBER

Program for Foreign Medical Graduates, Nov. 1 & Jan. 22, Miami*

Hepatobiliary Disease in Clinical Practice, Nov. 11-13, Miami*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 11-13, Miami*

Initial Management of the Pediatric Emergency, Nov. 17-21, Caesars Palace, Las Vegas, Nevada. For information: J. Clifford Findeiss, M.D., 3900 Northwest 79th Avenue, Suite 469, Miami 33166.

Legal and Medical Aspects of Human Sexuality, Nov. 18-20, Miami*

Third Workshop in the Use of Staplers in Surgery, Nov. 19-20, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Anesthesia Management for the Surgical Patient, Nov. 29-Dec. 12, Miami*

Emergencies in Internal Medicine, Nov. 30-Dec. 4, Miami*

1977

JANUARY

Pediatric Nephrology Seminar IV, Jan. 3-6, Miami*

Neuro-Ophthalmology Seminar, Jan. 3-7, Miami*

Midwinter Cruise—Symposium on Intensive Care, Jan. 6-15, Miami*

Miami Winter Symposia—Biochemistry, Jan. 10-14, Miami*

Human Disease Related to Food and Chemical Sensitivity, Jan. 12-15, Miami*

11th Annual Postgraduate Seminar in Surgery, Jan. 12-15, Miami*

Hematology and Oncology 1977, Jan. 13-16, Miami*

Nephrology 1977, Jan. 14-15, Miami*

Pulmonary Disease 1977, Jan. 14-15, Miami*

Arthritis 1977, Jan. 14-16, Miami*

Gastroenterology and Hepatology 1977, Jan. 14-16, Miami*

Internal Medicine 1977, Jan. 15-21, Miami*

Second Review and Practical Advances in Pathology, Jan. 16-21, Miami*

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

JANUARY (Continued)

9th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-22, Carillon Hotel, Miami Beach. For information: Charles Lynne, M.D., 1200 N.W. 10th Avenue, Miami 33136

Infectious Disease—Immunology 1977, Jan. 22-23, Miami*

Endocrinology 1977, Jan. 22-23, Miami*

Basic Sciences for the Practicing Physician: Biochemistry, Jan. 22-23, Miami*

Cardiology 1977, Jan. 24-26, Miami*

4th Annual Postgraduate Course in Practical Modern Neurology, Jan. 24-27, Miami*

Florida Midwinter Seminar on Ophthalmology, Jan. 30-Feb. 2, Miami*

FEBRUARY

Update on Cancers of the Gastrointestinal System, Feb. 3-5, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Florida Midwinter Seminar on Otolaryngology, Feb. 3-5, Miami*

What's New in Neurosurgery for the General Practitioner, Feb. 4-5, Gainesville Hilton, Gainesville.**

22nd Central Florida Medical Meeting, Feb. 4-6, Contemporary Resort, Lake Buena Vista. For information: Axel W. Anderson III, M.D., Suite 403, 85 West Miller Avenue, Orlando 32806.

3rd Annual Vail Conference in Anesthesiology, Feb. 5-12, Miami*

Thrombosis: Diagnosis, Prevention & Treatment, Feb. 7-9, Sonesta Beach Hotel, Key Biscayne. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Second Annual Seminar, Problems in Pediatric Radiology, Feb. 8-12, Dutch Inn, Lake Buena Vista.*

Symposium on Stroke—Moderns Trends in Cerebrovascular Disease, Feb. 9-12, Diplomat Hotel, Hollywood. For information: Mr. Ronald A. Nelson, Executor Director, Heart Association of Broward County, 440 N. Andrews Ave., Fort Lauderdale 33301

Winter Management (Anesthesiology), Feb. 12-19, Miami*

Recent Advances in Cardiopulmonary Care III, Feb. 25-26, Holiday Inn, Lido Beach, Sarasota. For information: Robert E. Windom, M.D., 1901 Arlington Street, Sarasota 33579.

Basic Neurology for Psychiatrists, Feb. 28-Mar. 4, Miami*

MARCH

Third Annual Pediatric Surgical Postgraduate Course, Mar. 3-5, Americana Hotel, Miami Beach. For information: William T. Brown, M.D., Chief, Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155.

Postgraduate Seminar in Dermatology, Mar. 4-6, Miami*

Skin 1977: What Every Nurse Should Know, Mar. 4-6, Miami*

Pediatric Anesthesia Seminar—Spring Cruise, Mar. 5-15, Miami*

Basic Medical Hypnosis, Mar. 13-19, Miami*

Seventh Annual Special Radiological Procedures Seminar, Mar. 19-22, Konover Hotel, Miami Beach.*

Fifteenth Annual Clinical Radiology Seminar, Advances in Cancer Diagnosis, Mar. 22-26, Konover Hotel, Miami Beach.*

9th Teaching Conference in Clinical Cardiology, Mar. 23-26, Miami*

Post-Conventional Seminar, Pathologic-Radiologic Correlations, Mar. 26-29, Caribbean Cruise.*

2nd Annual Vail Conference in Respiratory Therapy, Mar. 26-Apr. 2, Miami*

MAY

Master Approach to Cardiovascular Problems, May 5-7, Miami*

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MIAMI, FLORIDA AREA: Multispecialty group fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

ORTHOPAEDIC SURGEON — FLORIDA PRACTICE. Board qualified or certified to join 2-man highly reputable orthopaedic practice in beautiful community. Send professional and personal critique to L. Cerino, M.D., 1800 North Federal Highway, Pompano Beach, Florida 33062. Phone: (305) 943-1922.

ANESTHESIOLOGIST WANTED: Free standing, outpatient surgical facility, Dade County, Miami, Florida. Elective day time schedule, off weekends and holidays, no calls. Contact: Executive Director (305) 595-9511.

GROUP OF 15 BOARD CERTIFIED INTERNISTS, several subspecialty certified, seeks association of board eligible or certified internist with subspecialty training in rheumatology, infectious diseases, or cardiology. Excellent beautiful area. Write full credentials to C-744, P.O. Box 2411, Jacksonville, Florida 32203.

TWO ANESTHESIOLOGISTS NEEDED: Growing multispecialty group seeks affiliation with board certified or eligible anesthesiologists. Excellent opportunity to either join group or provide service to its staff and other physicians in the community. Beautiful northeast Florida coastal city with excellent hospitals and good school system. Write C-698, P.O. Box 2411, Jacksonville, Florida 32203.

OPENING FOR DERMATOLOGIST, in office with five established internists. Board certified or eligible. Take over established practice. Arrangements open. Reply to C-743, P.O. Box 2411, Jacksonville, Florida 32203.

IMMEDIATE OPENING FOR RADIOLOGIST. Liberal financial assistance, attractive guaranteed income. Must be Florida licensed or eligible. Contact Claude L. Weeks, Administrator, Flagler Hospital, P. O. Box 100, St. Augustine, Florida 32084. Phone: (904) 824-8411.

GENERAL INTERNIST, INTERNIST-CARDIOLOGIST, INTERNIST-RHEUMATOLOGY AND INTERNIST-PULMONARY DISEASE NEEDED for outstanding practice opportunities. Fifty physicians medical group affiliated with 312-bed hospital, located on Florida's Gulf Coast. Population doubling in five years. Advantages of group practice combined with prerogatives of solo practice. Fee for service arrangement with substantial drawing account first year. No investment required. For full details, contact D. M. Schroder, Mease Hospital and Clinic, Dunedin, Florida 33528. Phone: (813) 734-6365.

N E FLORIDA—SMALL CHILDREN'S HOSPITAL expanding Department of Anesthesiology. Immediate opening for staff anesthesiologist with pediatric experience, board certified or board eligible. Salary and benefits commensurate with experience. Contact: Chief of Anesthesiology, Hope Haven Children's Hospital, 5720 Atlantic Boulevard, Jacksonville, Florida 32207.

MISCELLANEOUS

ADDITIONAL PHYSICIANS URGENTLY NEEDED in rapidly growing Gulf Coast area. Most needed are internists, ENT's and pediatricians. Excellent private practice opportunity. Rural. Drawing area 40,000. 200-bed excellently equipped hospital. Excellent schools. One and one half hours from medical schools and metropolitan areas. Office space available. Send curriculum vitae to C-708, P.O. Box 2411, Jacksonville, Florida 32203.

EXPERIENCED E.R. PHYSICIANS NEEDED. Preferably ACER. New panel being formed at M.S.M.C., a 724-bed teaching hospital in Miami Beach. Excellent remuneration —fee-for-service plus overage. P.A. group. Teaching responsibilities also required. Eligible for Florida license. Please send curriculum vitae to: J. Weisberg, M.D., Director of Ambulatory Services, Mount Sinai Medical Center of Greater Miami, 4300 Alton Road, Miami Beach, Florida 33140.

LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact: Jake Truslow Company, P.O. Box E-S, Venice, Florida 33595. Phone (813) 485-4617.

PSYCHIATRIST/G. P. PHYSICIAN — Openings are anticipated from time to time in well established Community Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse, Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume', should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

WANTED: Physician to join several other physicians in emergency room practice in central Florida community hospital, 150 beds. Forty hour week. Benefits include three weeks vacation and two paid medical conferences. Starting salary $40,000 yearly. Must be graduate of U.S. medical school, have AMA internship, and some previous practice desirable. Florida license necessary. Contact: Jack Geeslin, M.D., Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726. Phone: (904) 357-3128.

SEEKING PHYSICIANS to relocate Marianna, Florida, trade area of 40,000 people. Recent professionals study indicated the immediate need for 7 physicians to supplement the 6 already here. Financial and business assistance available to qualified physicians. Contact Elwin O'Steen. Phone: (904) 482-4011.

CAREER ERP POSITION AVAILABLE with established group in large metropolitan medical center in Northeast Florida. Full specialty backup. Florida license required. Liberal salary with desirable fringes. Write C-714, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN AND SONOGRAPHER TRAINING PROGRAM. All aspects of Diagnostic Ultrasound will be covered including how to start and operate an Ultrasound Department. One month physician program with three months and one year sonographer programs for qualified persons. Special arrangements may be considered. Limited number of applicants accepted. For further information phone or write: J. J. Crittenden, M.D., Diagnostic Ultrasound Department, West Florida Hospital and Clinic, 8383 North Davis Highway, Pensacola, Florida 32504. Phone (904) 478-4460, Ext. 174.

PILOT-ENGINEER-LAWYER. Broad experience developing and constructing mall type shopping centers. Strong background in Mortgage Banking, leasing and promotions. Desires position with group or individual to build condominium office complexistrip mall. Care centers will put it all together. Resume on request. John Hallman, P.O. Box 530, Gordon, Ga. 31031. (912) 628-5437.

Situations Wanted

YOUNG BOARD CERTIFIED ENDOCRINOLOGIST, experienced, university trained, AOA. Desires full-time endocrinology position in Florida. Would consider DME or hospital based position for consultations and teaching. Bilingual Spanish and English. Write C-739, P.O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST, 31, excellent university residency, glaucoma fellowship, ABO Diplomate, military completed June, 1977, desires association or partnership in quality practice. Write C-747, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN: age 38, Board Eligible, seeks salaried position in private clinic, hospital or HMO group. Prefer Dade County area, but Collier, Broward, or Palm Beach counties also acceptable. Available September 1, 1976. Write C-733, P.O. Box 2411, Jacksonville, Florida 32203.

ALLERGIST: 40 years old, university trained and board certified. Desires relocation in Florida. Will send more vitae upon request. Contact: F. McCain, M.D. Phone: (919) 765-3756.

PATHOLOGIST, 36, married, board certified in anatomical and clinical pathology, 3 years experience in large medical center, passed FLEX, seeks position of associate or director, available December 1976. Write: E. B. Gador, M.D., 6 N. Sycamore Avenue, Aldan, Pennsylvania 19018. Phone: (215) 284-4497.

BOARD SURGEON—50 years old, Florida licensed, interested in developing outstanding emergency department or surgical assisting. Coast preferred. Member ACEP. Write C-737, P.O. Box 2411, Jacksonville, Florida 32203.

PHYSICIAN—ENGLISH DIPLOMA, 35 YEARS EXPERIENCE IN GENERAL PRACTICE, OBSTETRICS, ETC. Desires part-time employment in Government Hospital, prenatal clinic, etc., while studying for E.C.F.M.G. examination. Small salary would be a help. Write C-745, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRIC PRACTICE WANTED: Board certified pediatrician desires to purchase or gradually take over established, busy pediatric practice in coastal community. Write with full details to: M. Nahas, M.D., 59-21 Calloway Street, Apt. 7H, Corona, N.Y. 11368 or call evenings (212) 271-0114.

NEUROLOGIST, married, board-eligible, with four years experience in private practice in other states, seeking opportunities for solo practice. Will consider association with a neurological group or multispecialty groups. Florida licensed. Write C-740, P.O. Box 2411, Jacksonville, Florida 32203.

Practice Available

FLORIDA LICENSE REQUIRED: RADIOLOGIST plans retirement. Excellent building and equipment for sale or lease. Across street from 900-bed hospital, open staff X-ray department. Phone: (813) 682-4183 or Write: Ralph B. Hanahan, M.D., 1415 Lakeland Hills Blvd., Lakeland, Florida 33801.

PRACTICE FOR SALE: Family practice, well equipped office, Cape Canaveral area, situated on South Beach. Pleasant surroundings. Grossing $150,000. Potential for growth. Write C-730, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNAL MEDICAL PRACTICE in North Miami, Florida, available for sale. Write C-746, P.O. Box 2411, Jacksonville, Florida 32203.

Equipment for Sale

(1) REMINGTON R-2.2 electrostatic copier. (2) ADAMS physicians compact centrifuge. (3) METRIX doppler instrument Model ETo5. All in good condition. Contact: Dr. Paul Gamig, 909 Lakeshore Drive, Lake Park, Florida 33403. Phone: (305) 844-6759.

TWO GOOD modern examining tables, in excellent shape. Three wall otoscope, ophthalmoscope units with all accessories, and other miscellaneous equipment and office supplies. Very reasonable. Reply to: C. E. Menendez, M.D., P.O. Box 2778, Winter Haven, Florida 33880.

FOR SALE: ONE 15' BAHAMIAN SAILING DINGHY—fibreglass, teakwood fittings, sail and carrying trailer, $900; one Sajou's Encyclopedia of Medicine—a rare antique book collection; One Pelton Steam Autoclave; one Picker x-ray Unit, 300 ma, 125 pkv. 90/15 tilt table, fluoroscope, spot film device, floor to ceiling tube stand with electromagnetic locks, videx collimator, electronic bucky, 12/1 grid. Contact: Alex Trombly (813) 253-0481, 8:00 - 5:00.

FOR SALE: Radiographic equipment—250 MA-110KV Fisher generator, floor to ceiling tube stand, Dynamax 40 tube, Bucky flat table—good condition, $4,000. Call Dr. Jelaso (813) 446-6760, Clearwater.

Real Estate

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

ST. PETERSBURG: Pasadena Medical-Dental Building, 419 Pasadena Avenue South. New deluxe office building. Just minutes from Palms of Pasadena and St. Petersburg General Hospitals. Custom designed for your needs. For complete information call Gerald F. Dalrymple (813) 866-2474.

LAKELAND, FLORIDA: FOR SALE, 6% down. Air-conditioned office for one to three physicians. Main street, 168 x 140 ft.; double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

1973 NEW OFFICE BUILDING in medical complex, designed and furnished for two, 3100 sq. ft. One half available in July 1976. Contact Mrs. E. Pent (813-293-2147) 450 Avenue K, Southeast, Winter Haven, Florida 33880.

FOR RENT, WEST PALM BEACH: Unusually good central location on South Flagler Drive. New, one story building. Parking. Call (305) 655-8620, evening (305) 833-2952.

DESIRABLE SPACE AVAILABLE, ample free parking, janitor service, A/C, 440, 528, 1,104 sq. ft. 1333 S. Miami Avenue, Miami 33130. Suitable MD or other, reasonable terms. Manager on premises, Room 111. Phone: (305) 374-8210.

FOR LEASE: Completely equipped medical office including x-ray. 1,000 square feet, ground floor. Dadeland Medical Building, 7400 North Kendall Drive, Miami, Florida 33156. Call (305) 666-5911 or (813) 634-4433 after 5:00 p.m.

5% FINANCING FOR TWO 1,200 SQ. FT. SHELLS in doctor's office complex. Ideal spot for internists or GPs. Write: P.O. Box 2543, Port Charlotte, Florida 33952.

ACTIVE MEDICAL OFFICE adjoining large drug store in Southside Jacksonville for rent or purchase including drug store. For information call (904) 737-5390.

NEW MEDICAL DENTAL BUILDING, W. Palm Beach. Two story rental building. Preconstruction prices for October 1976 occupancy. Located between 2 major hospitals. Butler Medical Center, 200 Butler St., Write: P.O. Box 462, Palm Beach, Fla. 33480. Phone (305) 585-6346 or 659-6277.

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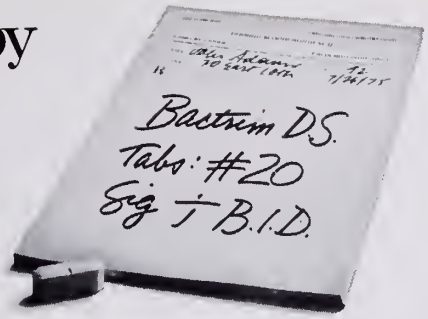
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10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

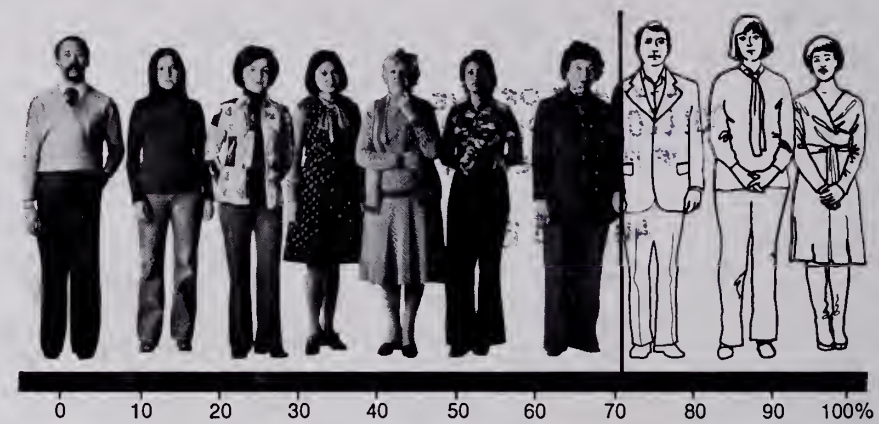
Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

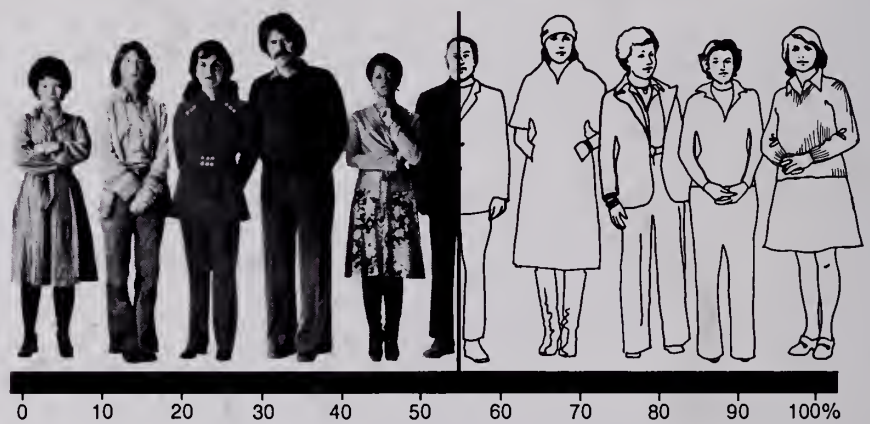
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In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS Double Strength tablets

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Please see summary of product information on preceding page.

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SEPTEMBER 1976 • VOL 63 • NO 9

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FMA Special Meetings in September (See Page 722)

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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This Issue

His Bundle Recordings in the Clinical Evaluation of Patients With Conduction Disturbances
Juan M. Aranda, M.D., Benjamin Befeler, M.D., Agustin Castellanos Jr., M.D. and Robert Myerburg, M.D. 695

Fasciitis (Eosinophilic) With Scleroderma-Like Changes in the Skin
John H. Talbott, M.D. and Benedict A. Cusani, M.D. 702

Special Articles

The Educated Heart
Donn L. Smith, M.D. 707

Sunshine Station—Florida's First Camp for Children With Asthma
Frederick L. Bloom, M.D., Dennis L. Spangler, M.D., Julia E. McMichael, M.D., Heinz J. Wittig, M.D. and Phyllis Upson, R.N. 710

Drug Substitution Law
Jack A. MaCris, M.D. 714

Notes on Russian Psychiatry
Philip B. Phillips, M.D. 715

The Changing Image of Medical Education in Brazil
James J. Cerda, M.D. and Emilio A. Francischetti, M.D. 718

Sections

President's Page
Will It Float?
JACK A. MACRIS, M.D. 685

Books Received 733

Book Reviews 732

Dean's Page
First Things First
CHANDLER A. STETSON, M.D. 689

From the Editor's Desk 692

Letters to the Editor 726

Medical News Around the State 728

Organization
Two FMA Members Honored 724

Information

Classified Advertising 735

FMA Officers and Council Chairmen 738

Information for Authors 733

Index to Advertisers 738

Meetings 731

SEPTEMBER COVER—The painting on the cover by Mrs. William F. Hogan (Mary), of Fort Lauderdale, won the Editor's Award at the Woman's Auxiliary Tenth Annual Benefit Art Show during the FMA Annual Meeting, May 5-9, 1976 in Miami Beach.



President's Page

Will It Float?

For two years we have been marooned on an island in the turbulent sea of malpractice insurance. We have built our little raft of legislative reform with the logs in our "omnibus bill," in hope of returning home to the practice of medicine. Now let us see if it will keep us afloat.

We did not get all the items that we thought we needed, and we were given Risk Management to take along. Now, after two years of effort in putting it together, it is time to set sail. This means getting a crew that is willing to devote some time and effort to make it work, because it won't drift home by itself.

The single most interesting, and perhaps most promising, item in the professional liability program, is the Mediation Panel. The search for a solution nationwide has been to find an equitable substitute for the tort system, which has proven to be too costly for our patients. Thus, a number of states chose arbitration as a solution. The Workmen's Compensation approach, and No-Fault, have been discussed at length. Our own long-range Malpractice Committee here in Florida pondered an "expert panel" approach. To date no substitute has been found which safeguards the rights of both the plaintiff and the defendant as well as does our present system. The Mediation Panel, however, preserves the right to a day in court while experimenting with a simpler, and hopefully quicker and less expensive, approach.

If the mediation panels are to be given a fair trial, we will need our most knowledgeable, and our most respected, and our most capable physicians around the state volunteering their efforts on behalf of our patients and our colleagues. Of course, this requires a sacrifice of time and effort by these men, but these demands are not new to physicians. If the mediation panel concept fails, let it not do so because we, as physicians, did not give it our best effort.

The second piece of legislation, which will require active participation on behalf of physicians, is Risk Management. Basically, this is employing the principles of good public relations in the fields of injury liability. It has been shown repeatedly that suits are begun oftentimes because the injured party was more unhappy about the manner in which he was treated, than about the injury itself. Thus, when a patient is upset about an incident which occurs in the hospital, it behooves the hospital and the attending physician to know about it as soon as possible, and to deal with it as directly and equitably as possible. If nothing else, it prevents the smoldering resentment which produces hostility, which is fertile ground for a suit.

Again, this calls for a considerable effort on the part of the Chief of the Medical Staff, especially if the Risk Management Panel must convene and carry out the entire hearing process. Yet, if this panel can resolve the matter to everyone's satisfaction, and prevent a suit from going to a jury, it certainly seems worth it. Being Chief of Staff need not be a lifetime job, and we can all take our turn as we have with many other duties connected with the practice of medicine.

There are, to be sure, some aspects of the Risk Management Law, which cause concern, but these can perhaps be changed, especially if they prove to be undesirable in actual practice. Let us not let these items stop us from giving the Risk Management concept a fair trial. It does have a track record here in our own state, and those institutions which have adopted it are enthusiastic about it. We may all end up as its boosters.

We asked the Florida Legislature for some help with the malpractice problem, and have received a package of laws dealing with the problem. We are now, in turn, obligated to put forth our best efforts in working with these laws and their new ramifications. Let's give it our best shot.

Jack A. Willis, M.D.

JUST ONE CHEWABLE TABLET

usually eradicates pinworms in both children and adults†



No dosage calculations

Vermox (mebendazole) offers a greatly simplified method of treating pinworm. Just one tablet, for every member of the family, regardless of weight or age.†

Simplicity of administration

Patients can take the tablet at any time. It can be chewed, swallowed, or crushed and mixed with food. No messy liquids to pour.

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Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

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Just one simple dosage, regardless of weight or age,† for single or mixed infections: 1 chewable tablet b.i.d. for 3 consecutive days. If the patient is not cured 3 weeks after treatment, a second course of treatment is advised.

†Because Vermox has not been extensively studied in children under 2 years of age, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

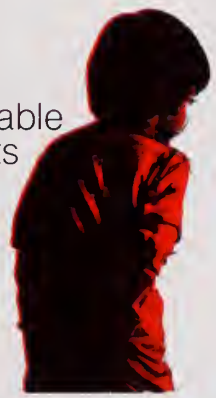
a single chewable tablet treatment for pinworm

Vermox

TRADEMARK

chewable tablets

(mebendazole)



DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. An insignificant amount of mebendazole is absorbed from the gastrointestinal tract. Most of this is excreted in the urine within three days either as metabolites or unchanged drug.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections.
Efficacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Trichuris	Ascaris	Hookworm	Pinworm
cure rates mean (range)	68% (61-75%)	98% (91-100%)	96% –	95% (90-100%)
egg reduction mean (range)	93% (70-99%)	99.7% (99.5-100%)	99.9% –	– –

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years, therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.
For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.
If the patient is not cured three weeks after treatment, a second course of treatment is advised.
No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium, and co-developed by Ortho Pharmaceutical Corporation.

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Consult product brochure before prescribing.

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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PIONEERS IN GERIATRIC RESEARCH



Dean's Page

First Things First

Chandler A. Stetson, M.D.

When Governor Askew vetoed those sections of the 1976 appropriations bill that would have led to the planning and implementation of a school of osteopathy and the initial funding of a school of optometry in Florida, his actions were based on firm data and sound principles. The incident serves to illustrate the relatively recent development of a capability for the assessment of health manpower needs and for the projection of health manpower supply.

As recently as a decade or two ago, there was considerable uncertainty as to how to determine the optimal numbers of physicians, nurses, and other health professionals needed for the United States at present and how to forecast the need for the future. A general philosophy of "the more the better" seemed to prevail, and both federal and state governments embarked upon sizeable expansion programs designed to increase the output of all health professionals and technologists.

In the last few years, there have been accumulated better data than ever before on the numbers and distribution and activities of physicians, both in this country and in others with a variety of health care delivery systems. Health planners, educators, practitioners, economists and legislators have worked together to get answers to complex problems that were simply not susceptible to solution in the 1950's. For example, it is now generally accepted that there is not likely to be any shortage of physicians over the next two decades. Computer models have been developed which permit forecasting of supply at least a few years ahead with what has been almost uncanny accuracy. Cost-containment studies have shown that an increase in the number of certain health professionals per unit population is more likely to result in an increase in fees rather than in the decrease that might have been expected as an effect of competition. As a result of these and other concepts, some of which are almost counter-intuitive, a more rational approach is being undertaken to the funding of the health professional educational system.

Of course, there is a risk in this—that those responsible for managing health education funding may go too far too fast in their enthusiasm to apply some of this new knowledge. Current federal health manpower legislation, for example, specifies details of curriculum and percentages of residencies in certain areas, and this not only represents unwarranted legislative intrusion into the academic affairs of universities but is pushing our current manpower-needs-assessment technology farther than is actually justified by facts and experience. Eventually, however, we may expect to see this technology used properly to help assure a good match between supply and demand.

In Florida, state general revenue has scarcely been adequate to properly support our present medical and dental education institutions recently, making the prospect of any new colleges of medicine or osteopathy or dentistry or optometry now quite out of the question.

Governor Askew is to be applauded for making sure that the state does not assume any new obligations in the health education field until it is better able to support our existing institutions.

Dr. Stetson, University of Florida College of Medicine, Gainesville 32601.

Dr. Stetson is Dean and Vice President for Health Affairs, University of Florida College of Medicine, Gainesville.

"Approximately 95% of the [U.S.] children of ages 1-5 years had iron intakes below the standard"

U.S. Public Health Service (1974)

Where did that surprising statistic originate?

From the first survey designed to assess the nutritional status of the entire U.S. population. The conclusion above was the most striking result reported in the preliminary findings released in January 1974.

Were they really dealing with a true sample of the entire U.S. population?

Those conclusions were based on a sample of 10,126 people—a probability sample established by the U.S. Bureau of Census to reflect the country's total population, regardless of race or income.

Among those 95% with substandard iron intake, how low was their intake actually?

For whites and blacks, for both sexes, for both income levels, the mean intake of iron (as a percent of the standard) for the 1-5 year age group ranged from 60 to 69%. Typically, then, 95 children out of 100 have iron intakes that are only ⅔ of the standard.

Whose iron intake standard were they using?

The standard set by the Food and Nutrition Board of the National Academy of Sciences for this group.

Implication of all this?

That iron deficiency among preschoolers is anything but rare and signs like mental apathy, lethargy, irritability, behavior problems, may be telegraphing iron deficiency.

Suggesting iron supplementation?

Not necessarily. In many instances this situation can be corrected by proper diet and, obviously, this is the preferred route. When dietary improvement is not attainable, consider a supplement.

But consistent use of an iron supplement is difficult to achieve.

Compliance is a problem, as so much of the recent data suggest.* INCREMIN with Iron Syrup has a pleasant flavor which encourages consistent use.

Is this cited study generally available?

Yes, from the Office of Information, National Center for Health Statistics, 5600 Fishers Lane, Rockville, MD., 20852. Request "First Health and Nutrition Examination Survey", 1974, DHEW Pub. No. (HRA) 74-1219-1.

*B. Blackwell: The Drug Defaulter. *Clinical Pharmacology and Therapeutics* 13:841 (1972).

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Vitamin B_{12}	25 mcgm
Sorbitol	3.5 Gm
Alcohol	0.75%

DOSAGE: Prevention of iron-deficiency anemia—Children and Adults—1 tsp. (5 cc) daily. Treatment of iron deficiency anemia—Children: 1 tsp. t.i.d.; Adults: 1 tsp. q.i.d.

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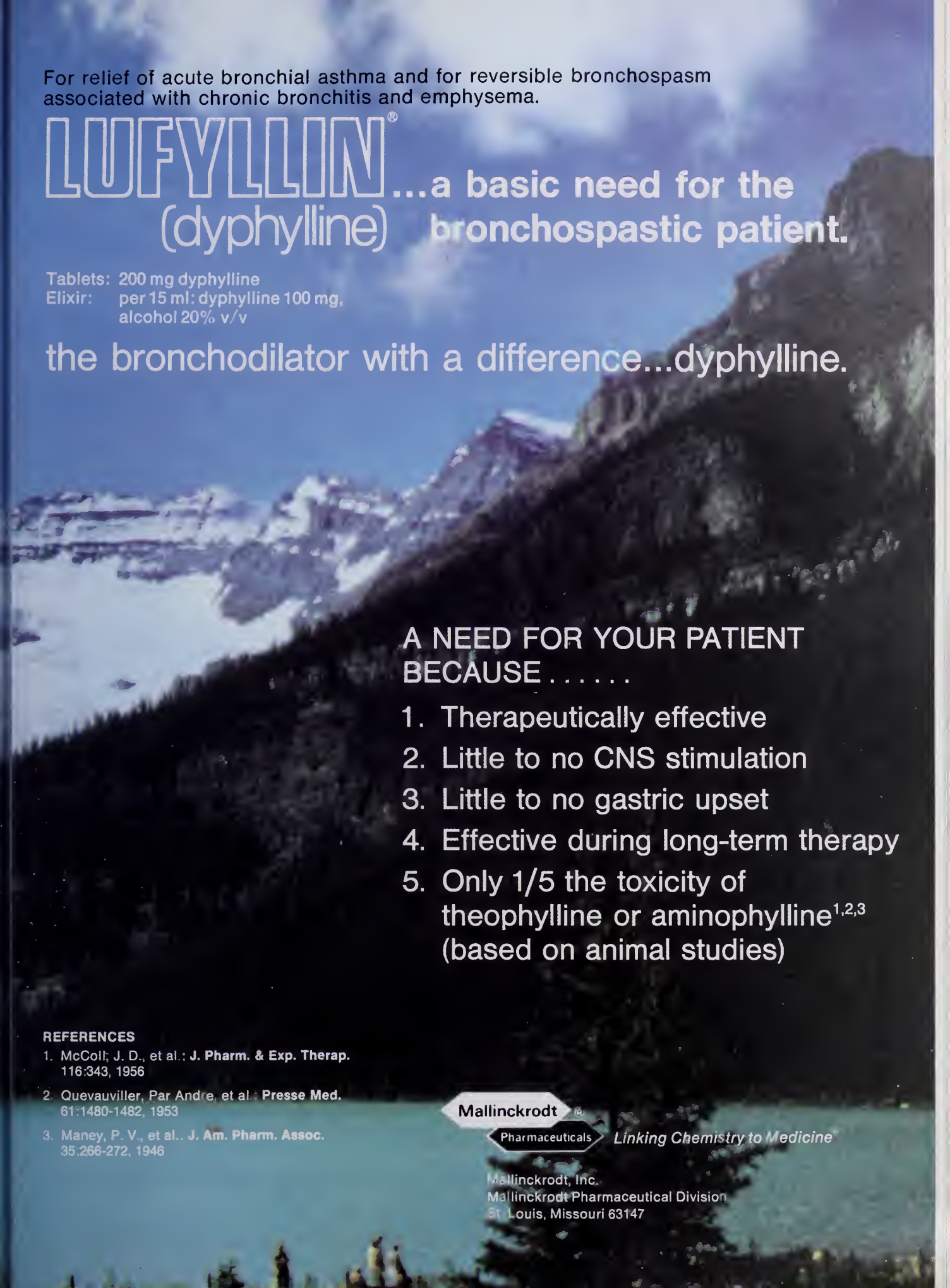
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REFERENCES
1. McColl, J. D., et al.: J. Pharm. & Exp. Therap. 116:343, 1956
2. Quevauviller, Par Andre, et al.: Presse Med. 61:1480-1482, 1953
3. Maney, P. V., et al.: J. Am. Pharm. Assoc. 35:266-272, 1946
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ADMINISTRATOR-FMA INSURANCE PLANS

ADMINISTRATOR

The FMA Income Protection Plan

For the past 20 years, the Florida Medical Association has sponsored the Income Protection Program to help protect its members and their families from the numerous financial problems total disability could cause. Since 1956, members have been able to purchase disability insurance through the program assuring them of an income if an accident or illness prevented their practice of medicine.

This program, underwritten by CNA Insurance's Continental Casualty Company of Chicago, is being updated to provide even more effective insurance protection for our members. . . .protection which meets today's needs at the lowest possible premium rate.

The new Income Protection Program offers members a greater selection of coverage options. It provides benefits from $25 to $450 per week, beginning the 31st, 61st, 91st or 181st day of total disability. Members may also select between a plan which pays benefits for up to five years or one which pays benefits up to age 65. This wide variety of coverage options allows members to tailor plans to fit their personal situations. It also helps eliminate duplicate benefits, resulting in more comprehensive and economical coverage.

The insurance industry practice of allowing an insured to purchase coverage up to 60% of his or her income also has been adopted by our revised program. This figure, used industry-wide, is the spendable income received after taxes and other payroll deductions have been taken into consideration. Since disability benefits are tax-free, the 60% figure represents the amount of coverage needed to duplicate our member's "take home" salary.

The Florida Medical Association's disability program was revised only after a careful study revealed modifications were needed to stabilize and modernize the plan. The new Income Protection Program is better able to provide the coverage needed today, to meet the financial problems caused when an accident or illness results in total disability.

For further information concerning the Plan, contact
The Professional Insurance Management Company (PIMCO)



FROM THE EDITOR'S DESK

Roughly a third of the nation's physicians are members of organized Professional Standards Review Organizations (PSROs). An estimate of 106,000 participants was made recently by Louis Hellman, M.D., head of the Health Services Administration, Department of Health, Education and Welfare. Dr. Hellman told Congress there are now 65 conditional PSROs and 55 in planning.

* * * *

A major crack seems to have occurred in labor support for the Kennedy-Corman National Health Insurance bill. Speaking at a national health conference, Teamsters Union Official Daniel Shannon said his union has become "increasingly distressed" by the concept of health care totally financed by the Federal Government. "Let's maximize the utilization of the private system rather than handing the entire problem over to the government," he suggested.

* * * *

Congress has enacted legislation aimed at preventing public marketing of medical devices that are not reliable or safe. Food and Drug Administration has always had authority to move against unsafe devices already on the market. The new legislation has three classifications of devices, including one requiring premarket approval. That category provides for premarket approval of implanted mechanisms or those considered to be life sustaining or supporting.

* * * *

State medical associations have received a pat on the back from AMA Executive Vice President James H. Sammons, M.D., for their work on the professional liability problem. Speaking at a meeting of state and AMA representatives called to discuss mutual concerns, Dr. Sammons called for future tete-a-tetes from time to time "to assess how far we've come and perhaps get an idea what to do next."

Bolstered by a $15,000 subsidy from the AMA, the fledgling American Retired Physicians Association continues to grow and now counts 1,570 members. Membership in the ARPA, formed last year, offers various benefits to physicians 55 or over and their spouses and widows. Information may be obtained by writing to the ARPA at Suite 906, 400 N. Michigan Ave., Chicago, Ill. 60611.

* * * *

Should physicians who receive government financial aid in their medical education be required to practice for a time in a shortage area? Almost half of the physicians responding to a poll published in American Medical News (45.4%) think so. In the 65 and over group, mandatory service was heavily favored (69.7%).

* * * *

Final regulations setting conditions for Medicare coverage of chronic kidney failure treatment have been published by the Department of Health, Education and Welfare. For three years now Medicare has covered virtually all Americans in the under 65 category who have permanent kidney failure when they need dialysis or transplant. The new regulations require treatment facilities to join together into networks to assure coordinated patient referral and access to resources.

* * * *

Florida is well represented this year at the highest level of the American Medical Association. Veteran AMA Delegate Francis T. Holland, M.D., Tallahassee, was elected Vice President of the AMA at the Annual Convention last June (see article in August issue of **The Journal**). Also, Jere W. Annis, M.D., Lakeland, was re-elected Vice Chairman of the Board of Trustees.

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Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

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His Bundle Recordings in the Clinical Evaluation of Patients With Conduction Disturbances

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Abstract: His bundle electrocardiography has enhanced our understanding of arrhythmias, the WPW syndrome and the site of conduction abnormality in patients with heart block. However, the usefulness of this procedure in the routine care of cardiac patients has been questioned. Three cases are presented to illustrate the potential and practical value of His bundle recordings in the evaluation and clinical management of patients with conduction disturbances.

His bundle electrocardiography (HBE) combined with electrical stimulation of the heart has provided a sophisticated means of evaluating the conduction system of the heart.[1-2] His bundle recording have enhanced our understanding of arrhythmias,[3] the Wolff-Parkinson-White syndrome[4-5] and the site of conduction abnormality in patients with various forms of heart blocks.[6] In addition the technique has been utilized extensively to study different physiologic[7] and pharmacologic interventions in experimental animals.[8-9] On the other hand, it has been stated that the usefulness of HBE in the management of patients with heart disease has been limited and that its role in the routine care of cardiac patients is yet to be determined.[10]

The clinical data and follow up of the last 30 patients who had undergone HBE in our institution were reviewed with special emphasis on the contribution of this technique in the management of the patients. The following cases illustrate the potential value of His bundle electrograms in the evaluation of patients with conduction disturbances.

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Methods

The technique for His bundle recordings used in our department has been previously described.[11] A tripolar catheter is introduced percutaneously through a femoral vein and is positioned across the septal leaflet of the tricuspid valve. Two bipolar leads with interelectrode distances of 1 and 11 mm. respectively (HBE_1 and HBE_2 leads) are recorded. In addition, two bipolar catheters with interelectrode distance of 1 mm. and 1 cm. are introduced through an antecubital vein and placed in the high right atrium for recording (1mm.) and pacing (1 cm.). The terminals from the electrodes are fed into a distribution switch box, the outputs of which are connected to the input of the recording instrument (Electronics for Medicine, White Plains, New York). Leads 1, 2, AVF and V_1 are obtained simultaneously with the filtered (400-2000 H_2) bipolar or unipolar intracardiac leads. The stimulator used for continuous coupled or paired pacing delivered slightly underdamped pulses, 2.5 msec in duration and twice the diastolic threshold values.[12] During atrial paired pacing the interval between the driving (St_1) and testing stimuli (St_2) is progressively shortened in order that the whole cycle might be scanned. His bundle pacing was performed in two of the patients reported (Cases 1 and 3). The following intervals were measured during sinus rhythm and continuous atrial pacing:

1. P-A interval (representing intra-atrial conduction time) was measured from the beginning of the P wave in the surface leads to the local atrial electrogram in the HBE leads (normal values 20-40 msec).

2. A-H interval (A-V nodal conduction time) was measured from the onset of the local atrial

electrogram in the HBE lead (low right atrium) to the initial deflection of the His electrogram (normal value 50-120 msec).[11]

3. H-V interval (conduction time in specialized ventricular—Purkinje system) was measured from the initial deflection of the His electrogram to the onset of ventricular depolarization (QRS) in the surface or HBE leads (normal 35-55 msec).

Informed consent was obtained from each patient prior to the study.

Case Presentations

Case 1.—This 69-year-old male was admitted to the hospital for evaluation of dizzy spells and one syncopal episode. An electrocardiogram taken in 1969 was normal except for left anterior hemiblock. A second tracing taken in 1973 (six months before admission) showed complete LBBB with normal axis in the frontal plane. The PR interval was 0.18 seconds. The electrocardiogram at the time of admission showed complete LBBB with a QRS axis of -40 in the frontal plane (Fig. 1). The PR interval was 0.20 seconds. The results of the physical examination were negative except for paradoxical splitting of the second heart sound. There was no evidence of postural hypotension or hypoglycemia. The chest x-ray revealed the heart size to be at the upper normal limit. Skull series, brain scan as well as a complete neurological work up were negative. Several 24 hour Holter monitoring studies showed sinus tachycardia with occasional premature atrial contractions.

Electrophysiological Studies

On the day of the procedure the resting sinus rate was 68 beats per minute (Fig. 2). The PR interval was 220 msec. The P-A and A-H intervals were normal. However, the H-V interval was prolonged to 80 msec. During atrial pacing the patient developed block proximal to the His bundle (in the A-V node) at a pacing rate of 140/minute (normal response).

In view of the electrophysiologic findings and considering the clinical picture suggestive of episodic complete A-V block, a permanent demand ventricular pacemaker was recommended. After insertion of the cardiac pacemaker, the neurologic symptoms disappeared and the patient has been asymptomatic for 12 months. In his last clinical evaluation, inhibition of the permanent pacemaker with external chest wall stimulation revealed complete atrioventricular block with an escape ideoventricular rhythm at a rate of 45 per minute.

Comments

The important therapeutic decision taken in this patient demanded a critical review of the significance of prolonged H-V intervals in patients with bundle branch block. In these cases, H-V prolongation reflects conduction delay in the functional bundle branch and is a manifestation of bilateral bundle branch block.[6,13] Previous reports suggest that patients with the electrocardiographic findings of bifascicular block (or partial bilateral bundle branch block) have an increased risk of developing complete atrioventricular block, which may result in transient neurologic symptoms.[14-16] However, partial bilateral bundle branch block (bifascicular block) may be an incidental electrocardiographic finding and complete A-V block may never develop in patients with this pattern.[17] His bundle electrocardiography allows localization and perhaps quantification of A-V conduction disturbances. Narula and Samet[18] reported marked prolongation of the H-V interval (mean of 85 msec) in patients with RBBB and left anterior hemiblock who subsequently developed higher degrees of A-V block. Our observa-

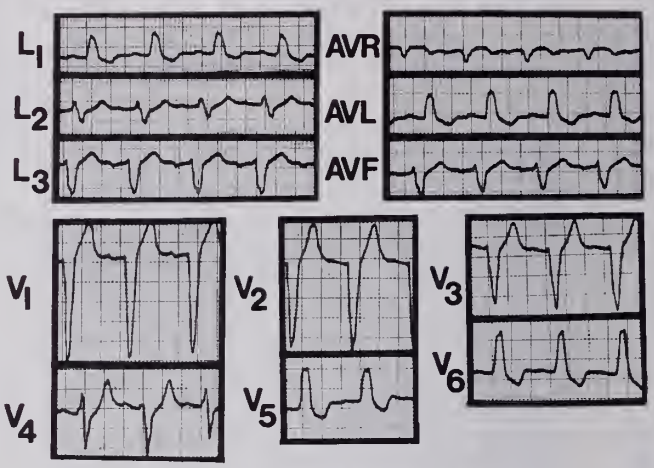


Fig. 1.—Case 1. Electrocardiogram obtained at the time of admission. Complete left bundle branch block with left axis deviation is noted. The PR interval was 0.20 seconds.

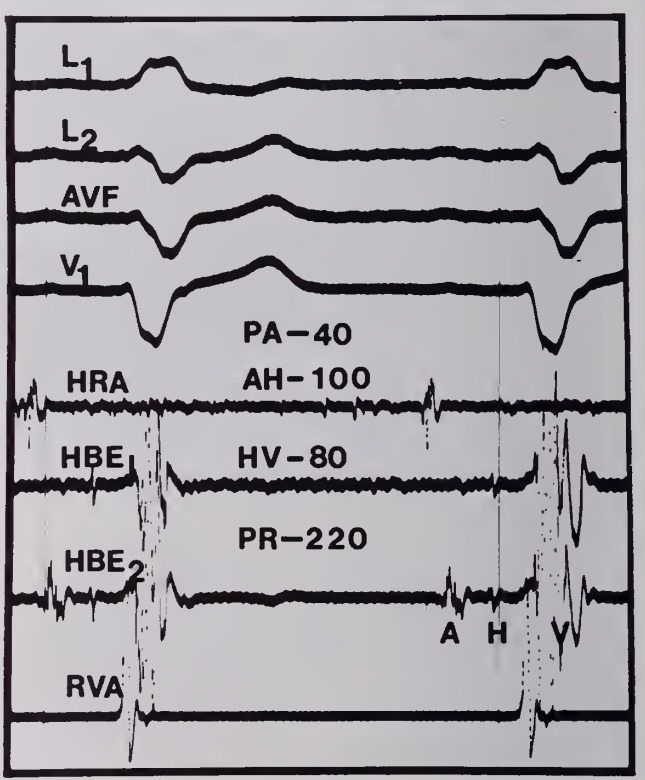


Fig. 2.—Case 1. His bundle recordings revealed normal P-A and A-H intervals. The H-V interval was significantly prolonged to 80 msec. The PR interval was 220 msec, the rate 68 per minute.

tions agree with the data presented by Scheinman et al[19] who suggested that patients with transient neurologic symptoms, bifascicular or LBBB associated with marked prolongation of the H-V interval (>80 msec), should be seriously considered as candidates for insertion of permanent cardiac pacemakers even in the absence of documented high grade or complete A-V block.

Case 2.—A 49-year-old male, with a previous myocardial infarction in 1971, was admitted to the CCU because of severe retrosternal chest pain and diaphoresis of two hours duration. The electrocardiogram showed an old inferoposterior myocardial infarction, narrow QRS complex, marked left axis deviation and elevation of the ST segment in the anterior precordial leads. Forty-eight hours after admission, he developed complete RBBB and a PR interval of 0.23 sec. (Fig. 3). His bundle electrograms recorded at the time of insertion of a temporary prophylactic pacemaker revealed a prolonged H-V interval of 60 msec. Fourteen days after admission the electrocardiogram (Fig. 4) showed sinus rhythm with a prolonged PR interval, marked left axis deviation suggestive of left anterior hemiblock and a recent anterolateral myocardial infarction. The RBBB reverted to an intraventricular conduction disturbances with a QRS complex of 0.10 to 0.11 sec.

Electrophysiologic Studies

His bundle electrograms (Fig. 5) showed normal P-A and H-V intervals. The A-H interval (A-V nodal conduction time) was prolonged to 130 msec. Atrial pacing up to a rate of 110 per minute showed prolongation of the A-H interval to 145 msec. No evidence of block proximal or distal to the His deflection was observed. The patient was discharged home without a permanent pacemaker, but he moved to another city three months later.

Comments

The mortality rate associated with incomplete bilateral bundle branch block complicating acute myocardial infarction is high.[20,21] The primary cause of death has been thought to be cardiogenic shock or arrhythmias including complete heart block, asystole and ventricular fibrillation.[21-22] Although the insertion of a temporary prophylactic pacemaker is still controversial, many authors recommend insertion but are aware that the benefit will be small.[16,20,23-25]

Recent reports have suggested that His bundle recordings may be of clinical importance in patients with acute myocardial infarction complicated by incomplete bilateral bundle branch block.[26] These observations suggest that those patients with bifascicular block and prolonged H-V intervals are at a higher risk for developing complete A-V block. His bundle recordings seem to be of value in determining the short term prognosis in this group of patients. The prognosis is poor for those with prolonged H-V intervals and persistent RBBB and better for those with a normal H-V interval and transient RBBB. Although it has been suggested that persistent right bundle branch block with left axis deviation in acute myocardial infarction might be an indication for permanent cardiac pacing[23,27] further observations and controlled studies are required to validate this statement.

Considering the delayed onset and transient nature of the bundle branch block associated with a normal H-V interval (at the time of the second HBE), it is reasonable to conclude that prophylactic permanent pacing was not required in the case presented.

It is possible that serial measurements of H-V intervals during the acute stage would identify a subgroup of patients that might benefit from a permanent pacemaker. More patients with acute myocardial infarction complicated by incomplete bi-

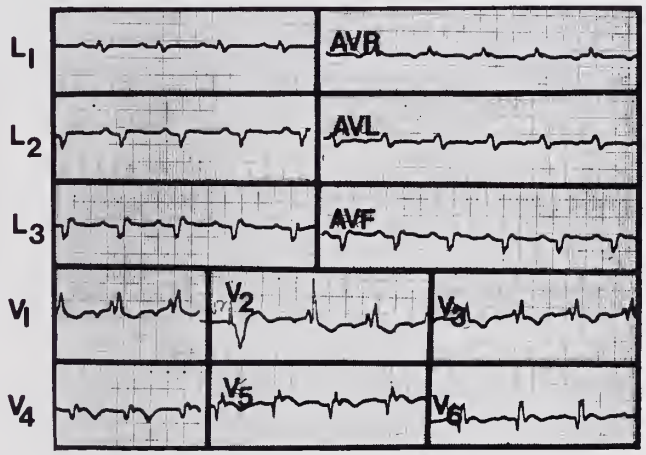


Fig. 3.—Case 2. Electrocardiogram 48 hours after admission to the CCU. Complete RBBB, marked left axis deviation and prolonged P-R interval are noted. A paced beat is seen in V_2. There is evidence of an old inferior as well as an acute antero-lateral infarctions.

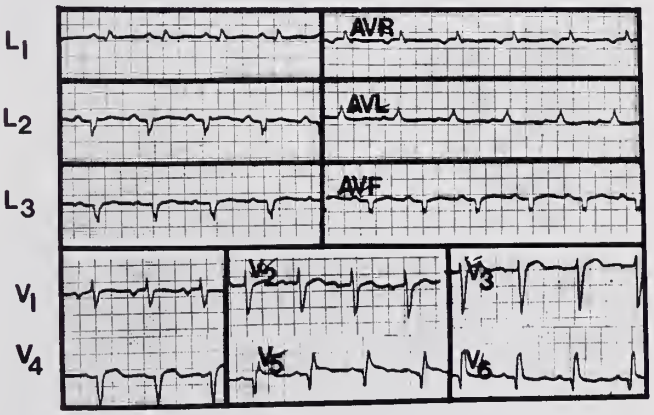


Fig. 4.—Case 2. Electrocardiographic tracing recorded 14 days after admission to the CCU (12 days after insertion of temporary pacemaker). Note the prolonged PR interval, marked left axis deviation and an intraventricular conduction disturbance with a QRS complex of 0.10 to 0.11 seconds. An old inferoposterior as well as a recent anterolateral myocardial infarction are present.

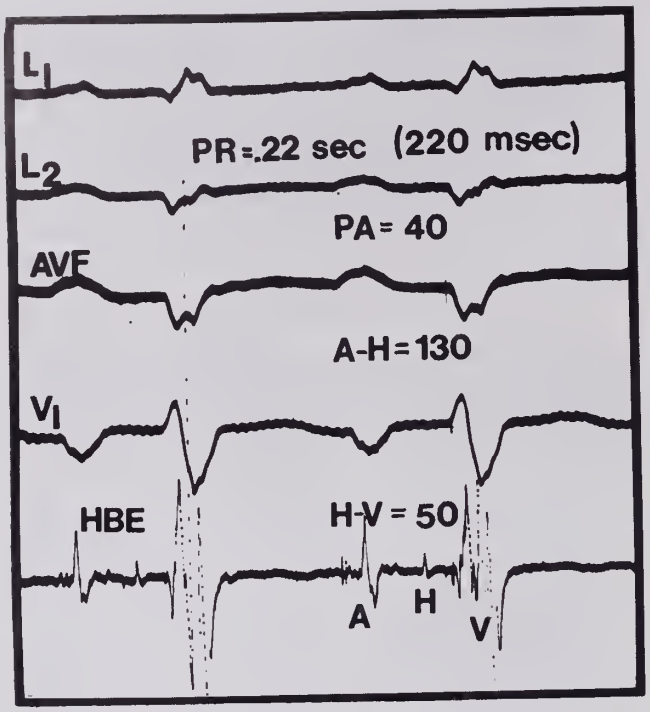


Fig. 5.—Case 3. His bundle recordings 15 days after the acute myocardial infarction. The P-A and H-V intervals are within normal limits. The A-H interval is slightly prolonged. The PR interval is 220 msec.

lateral bundle branch block need to be followed up for longer periods of time to determine the effect of such intraventricular conduction disturbances on ultimate prognosis.

Case 3.—This 69-year-old male was followed in the outpatient clinic because of RBBB, left axis deviation and first degree A-V block (Fig. 6). He was admitted for evaluation because of dizziness and fainting spells. There was no history of hypertension, diabetes or coronary artery disease. The results of the physical examination were unremarkable except for the presence of a fourth heart sound. Neurologic work up was negative. Brain scan and flow studies were suggestive of decrease blood flow in the area supplied by the right middle cerebral artery. Several 24 hours Holter monitoring studies were normal except for sinus bradycardia (56/minute).

Electrophysiologic Studies

During sinus rhythm at a rate of 60 per minute, the A-H and H-V intervals were 130 and 50 msec respectively. During atrial paired pacing, the patient developed reciprocating A-V junctional tachycardia (Fig. 7) at a rate of 150 beats per minute. The arrhythmia terminated spontaneously. Immediately after the end of the tachycardia there was a period of A-V block during which the atrial deflections apparently failed to activate the His bundle. The corresponding P-P interval preceding the first conducted sinus beat measured 1640 msec. The prolonged duration of this interval suggested the coexistence of sinus node dysfunction. During this episode, which occurred in the Cardiovascular Laboratory, the patient developed symptoms which were similar to those that he experienced before admission to the hospital. Three explanations appeared possible to explain the symptomatic post tachycardia A-V nodal block: (a) post-tachycardia induced period of abnormally prolonged A-V nodal refractoriness; (b) pseudo A-V block produced by concealed A-V junctional tachycardia and (c) bradycardia-dependent (phase 4) A-V block at the "upper" His bundle.[28]

A permanent pacemaker was recommended because reciprocating A-V junctional tachycardias occurred in a symptomatic patient with sinus node dysfunction. Digoxin was given in an attempt to prevent the tachyarrhythmias. He has been asymptomatic for 10 months.

Comments

The reported incidence of development of heart block in patients with bifascicular block, especially right bundle branch block and left anterior hemiblock has ranged from 6% to 30% over a period of several months to several decades.[15, 16, 29] A recent prospective study on the natural history of these patients showed that progression of conduction disease was uncommon, occurring in only 6% of patients during a mean follow-up period of 1½ years.[30] In this series, patients with both normal and prolonged H-V intervals had a relatively high incidence of sudden cardiac death which could have been secondary to progression of conduction disease or ventricular fibrillation.[30] Watanabe et al[31] recently reported a higher incidence of ventricular arrhythmias in patients with intraventricular conduction defects than in patients with normal intraventricular conduction and when these are subjected to graded exercise, they manifest premature atrial and ventricular beats and occasionally ventricular tachycardia.[32] In the case presented, symptoms could have been due to complete A-V block or to ventricular tachycardia. Sinus node dysfunction and reciprocating A-V junctional tachycardia were not suspected to be the contributing factors accounting for his clinical presentation. The information derived from His bundle electrocardiography was useful in the management of the patient and provided possible mechanisms which could be useful in understanding the genesis of symptomatic post tachycardia A-V block in patients with tachycardia-bradycardia syndrome.

Discussion

His bundle electrocardiography has been primarily considered a research technique useful in studying the conduction system of the heart and the effects of pharmacologic and physiologic interventions on A-V conduction. At the present time there are several clinical situations where critical information can only be obtained through His bundle recordings. As demonstrated in Case 1, His bundle recordings appear to be of clinical value in patients with neurologic symptoms and bundle branch block. Scheinman et al[19] reported three groups of patients

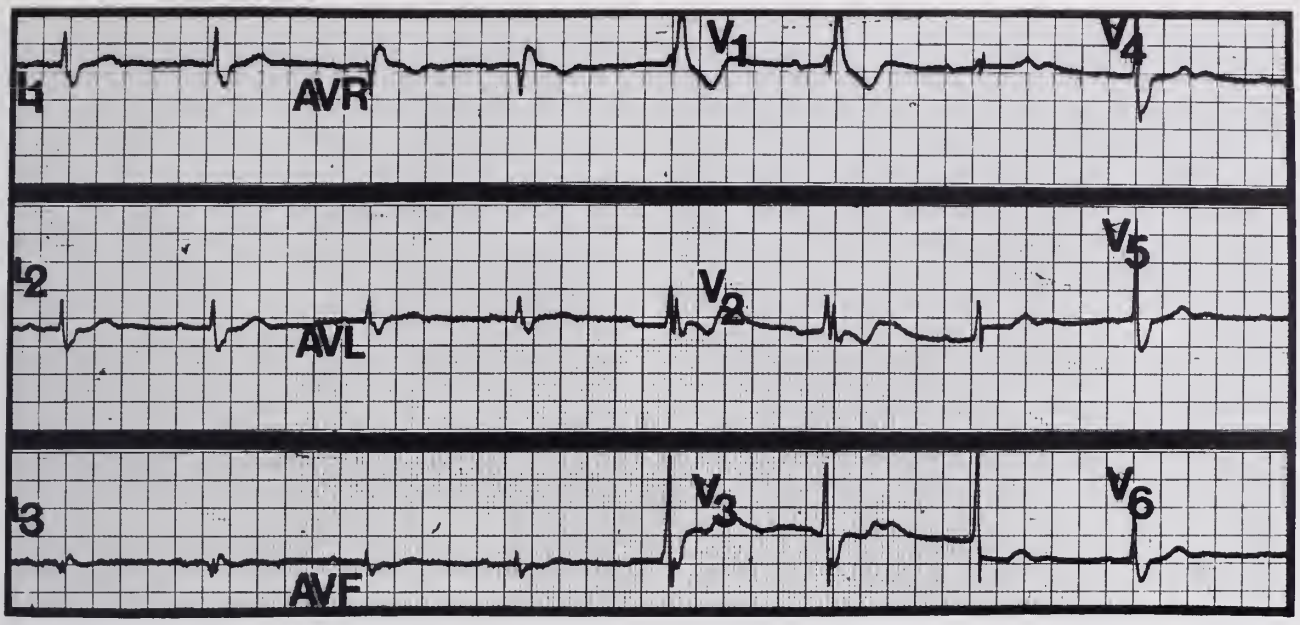


Fig. 6.—Case 3. Electrocardiogram taken at the time of admission. Complete RBBB, left axis deviation and first degree A-V block are present. The sinus rate is 56 per minute.

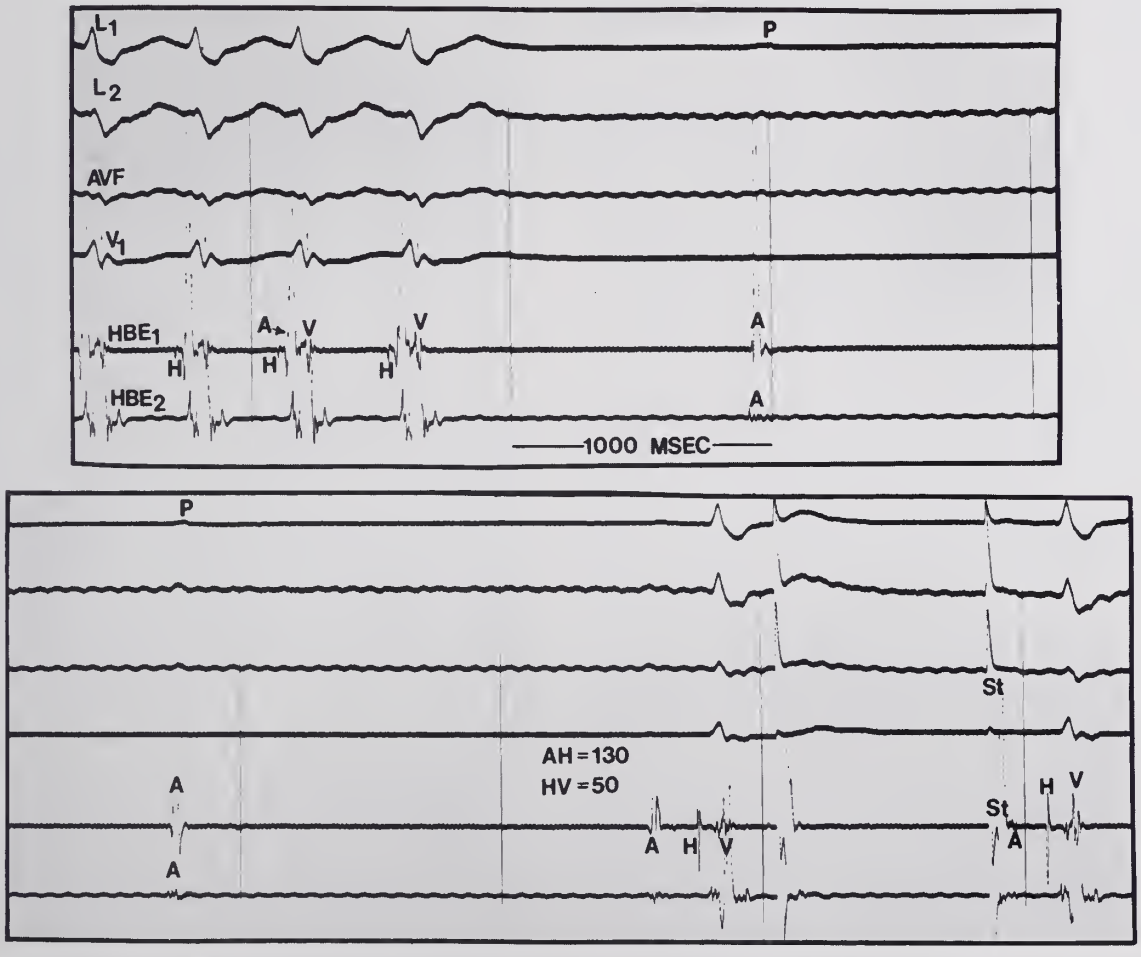


Fig. 7.—Case 3. Reciprocating A-V junctional tachycardia observed at the time of the His bundle recordings; the strips are continuous. The low right atrial electrogram was lost within the ventricular deflections of the HBE lead. Immediately after the termination of the tachycardia, there was a period of A-V block during which the atrial deflections failed to activate the His bundle.

with bundle branch block, dizziness, seizures or syncope and the presence of 1:1 antegrade A-V conduction at the time of the His bundle recordings. None of the patients studied had evidence of an acute myocardial infarction or symptoms of congestive heart failure. In six patients neurologic symptoms were observed in the absence of electrocardiographic evidence of A-V block. The H-V interval in this group of patients was normal or minimally prolonged (mean 56±9). In six other patients, the cause of the symptoms was not clear, however, in three patients the symptoms were of sufficient concern to merit implantation of a permanent cardiac pacemaker. Two of these patients experienced relief of symptoms suggesting that they were in fact related to transient bradyarrhythmias. The mean H-V interval in this group was 64±11 msec. In seven other patients complete A-V block was documented as the cause of the symptoms. The H-V interval was significantly prolonged in every patient, with a mean value of 89±20 msec. All patients with presumed or documented episodes of high grade A-V block had abnormal H-V intervals and six of the nine patients had H-V intervals over 80 msec. The significantly greater H-V interval in patients with documented A-V block, suggested that the specialized ventricular conduction system is involved in a progressive disease process the end stage of which results in complete A-V block.[19] The authors suggested that patients with chronic bundle branch block, marked H-V prolongation and transient neurological symptoms be considered as candidates for permanent pacemaker implantation. On the other hand, a previous study has demonstrated that a normal H-V interval in patients with bundle branch block does not preclude development of complete A-V block.[33] However, these observations have not been confirmed by others. A recent report by Vera et al[34] provided evidence that a considerably lengthened H-V interval in bifascicular block is not only a usual prerequisite but also strong evidence for impending heart block. In view of this, it remains to be determined if His bundle electrocardiography can provide a means to quantitate A-V conduction disturbances.

The indications for permanent cardiac pacemakers after an acute myocardial infarction remain a controversial issue.[16,23,27,35] Atkins et al[27] reported 16 patients with acute myocardial infarction and RBBB-LAD. Twelve patients had complete heart block in the first 48 hours, one of these patients died and 11 were temporarily paced. The pacemakers were removed in seven of the 11 patients after reversion to sinus rhythm. Eight patients died suddenly and unexpectedly between two weeks and four months after the infarction. Seven of these had transient heart block during the acute stage and three patients had documented recurrent complete heart block. On the basis of this data they suggested that persistent RBBB with LAD in acute myocardial infarction might be an indication for permanent pacemakers. Later Scalon et al[16] and Godman et al[22] described seven patients with RBBB-LAD who had transient complete heart block during an acute myocardial infarction; six of these patients died within eight months. Considering these reports and in view of their previous experience, Atkins et al[23] later restricted their recommendation to the group of patients with persistent RBBB-LAD who had developed transient complete A-V block during the acute stage of myocardial infarction. They found that 11 of 13 patients who did not have a permanent pacemaker died within eight months of discharge, whereas eight with permanent pacemakers were still alive. The possibility that sudden death might have been secondary to ventricular fibrillation during an acute ischemic episode was considered in a recent reappraisal of their report.[23] At the other end of the spectrum, Waters and Mizgala[35] recently reported their experience with 27 patients with acute myocardial infarction complicated by incomplete bilateral bundle branch block, treated with temporary transvenous pacemakers. Twelve of the 27 patients died in the hospital. Progression to complete heart block occurred in nine of the 12 patients. Fourteen of the 15 survivors have been followed up an average of 16.7 months after infarction and none had developed complete heart block. In seven of the survivors, follow-up studies indicated a trend toward regression of the conduction disturbances. The authors did not believe that the occurrence of transient complete heart block in patients with an acute myocardial infarction complicated by incomplete bilateral bundle branch block is an indication for permanent pacemaker insertion. In view of these conflicting observations it is reasonable to examine the value of His bundle electrograms in relation to the short term prognosis in this group of patients. In the series reported by Lichstein et al[20] and Lie et al,[26] His bundle recordings were made in 50 patients at the time of temporary pacemaker insertion. Twenty-one of the 27 patients with bifascicular block and prolonged H-V interval died in comparison to ten deaths in 23 patients with bifascicular block and a normal H-V interval. A very interesting observation

can be made by analyzing the data reported by Lichstein et al.[20] Of the patients with an abnormal H-V interval (55 msec or greater) eight died and three survived. In this group, there were five patients with H-V intervals of 70 msec or greater (range 70-100 msec), all of them died. All of the six survivors had H-V intervals less than 70 msec (range 45-65 msec). Although further observations and controlled studies are needed, this preliminary data suggests that His bundle recordings provide an important tool that might be used to quantitate A-V conduction disturbances. Whether permanent cardiac pacing is indicated in the group of patients with abnormal H-V intervals remains to be determined.

As we expand our understanding of the pathophysiology of conduction disturbances and cardiac arrhythmias, the information derived from His bundle recordings will become more useful in the management of patients with intraventricular conduction disturbances.

References

1. Damato, A. N.; Lau, S. H.; Patton, R. D. et al: A Study of Atrioventricular Conduction in Man Using Premature Atrial Stimulation and His Bundle Recordings, Circulation 40:61-69, 1969.
2. Castellanos, A. Jr.; Castillo, C., and Agha, S.A.: Contribution of His Bundle Recordings to Understanding of Clinical Arrhythmias, Am. J. Cardiol. 28:499-508, 1971.
3. Goldreyer, B. N. and Bigger, J. T. Jr.: Site of Re-entry in Paroxysmal Supra-Ventricular Tachycardia in Man, Circulation 43:15-26, 1971.
4. Castellanos, A. Jr.; Myerburg, R. J.; Craparo, K. et al: Factors Regulating Ventricular Rates During Atrial Flutter and Fibrillation in WPW Syndrome, Br. Heart J. 35:811-816, 1973.
5. Wellens, H. J. and Durrer, D.: Wolff-Parkinson-White Syndrome and Atrial Fibrillation, Am. J. Cardiol. 34:777-782, 1974.
6. Rosen, K. M.; Shahbudin, H.; Rahimtoola, M. B. et al: Electrophysiological Significance of First Degree Atrioventricular Block With Intraventricular Conduction Disturbance, Circulation 43: 491-502, 1971.
7. Cohen, S. I.; Lau, S. H., Scherlag B. J. et al: Alternate Patterns of Premature Ventricular Excitation During Induced Atrial Begeminy, Circulation 39:819-829, 1969.
8. Berkowitz, W. D.; Wit, A L.; Lau, S. H. et al: The Effects of Propranolol on Cardiac Conduction, Circulation 40:855-862. 1969.
9. Rosen, K. M., Lau, S. H., Weiss. M. B. et al: The Effect of Lidocain on Atrioventricular and Interventricular Conduction in Man, Am. J. Cardiol. 25:1-5, 1970.
10. Fisch, C. and Zipes, D. P.: His Bundle Electrocardiography, Am. Heart J. 86:289-291, 1973.
11. Castillo, C. A. and Castellanos, A. Jr.: His Bundle Recordings in Patients With Reciprocating Tachycardias and WPW Syndrome, Circulation 42:271-285, 1970.
12. Castellanos, A. Jr.; Centurion, M. J.; Lemberg, L. et al: Concealed Digitalis Induced Arrhythmias Unmasked by Electrical Stimulation of the Heart. Am. Heart J. 73:484-490, 1967.
13. Rosen, K.: Catheter Recordings of His Bundle Electrograms, Mod. Concepts Cardiovasc. Dis. 42:23-28, 1973.
14. Lasser. R. P. and Haft, J. I. and Friedberg, C. K.: Relationship of Right Bundle Branch Block and Marked Left Axis Deviation to Complete Heart Block and Syncope, Circulation 37:429-437, 1968.
15. Ranganathan, N., Dhurandhar, R.; Phillips, J. H. et al: His Bundle Electrogram in Bundle Branch Block, Circulation 45:282-294, 1972.
16. Scalon, P. J.; Pryor, R.; Blount, S. G. et al: Right Bundle Branch Block Associated With Left Superior or Inferior Intraventricular Block, Clinical Setting, Prognosis and Relation to Complete Heart Block, Circulation 42:1135-1142, 1970.
17. Dhingia, R.; Chuquimia, R.; Wu, D. et al: Short Term Prospective Follow up of Patient With Chronic Right Bundle Branch Block and Left Posterior Hemiblock, Am. J. Cardiol. 35:132, 1975 (abstract).
18. Narula, O. S. and Samet, P.: Right Bundle Branch Block With Normal, Left or Right Axis Deviation, Am. J. Med. 51:432-455. 1971.
19. Scheinman, M.: Weiss, A. and Kunkel, F.: His Bundle Recordings in Patients With Bundle Branch Block and Transient Neurologic Symptoms, Circulation 48:322-330, 1973.
20. Lichstein, E.; Gupta, P. K.; Chadda, P. et al: Findings of Prognostic Value in Patients With Incomplete Bilateral Bundle Branch Block Complicating Acute Myocardial Infarction, Am. J. Cardiol. 32:913, 1973.
21. Scheinman, M. and Brenman, B.: Clinical and Anatomic Implications of Intraventricular Conduction Blocks in Acute Myocardial Infarction, Circulation 42:1135, 1970.
22. Godman, M. J.; Lassers, B. W., and Julian, D. G.: Complete Bundle Branch Block Complicating Acute Myocardial Infarction, N. England J. Med. 282:237, 1970.
23. Atkins, J. M.; Leshin, S. J.; Blomgvist, G., et al: Ventricular Conduction Blocks and Sudden Death in Acute Myocardial Infarction, N. England J. Med. 288:281, 1973.
24. Fenig, S. and Lichstein, E.: Incomplete Bilateral Bundle Branch Block Complicating Acute Anterior Wall Myocardial Infarction, Am. Heart J. 84:38, 1972.
25. Roos, J. C. and Dunning, A. J.: Right Bundle Branch Block and Left Axis Deviation in Acute Myocardial Infarction, Br. Heart J. 32:847, 1970.
26. Lie, K. I.; Wellens, H. J.; Reinier, M. et al: Factors Influencing Prognosis of Bundle Branch Block Complicating Acute Anterosepted Infarction, Circulation 50:935, 1974.
27. Atkins, J. M.; Leshin, S. J.; Blomgvist, G. et al: Prognosis of Right Bundle Branch Block and Left Anterior Hemiblock: A New Indication for Permanent Pacing, Am. J. Cardiol. 26:624, 1970 (abstract).
28. Aranda, J. M.; Moleiro, F.; Castellanos, A. Jr. et al: A-V Block Following Reciprocating A-V Junctional Tachycardia, Am. J. Cardiol. 36:807-809, 1975.
29. Schloff, L. D.; Adler, L.; Donoso, E. et al: Bilateral Bundle Branch Block. Clinical and Electrocardiographic Aspects, Circulation 35:790, 1967.
30. Denes, P.; Dhingra, R. C.; Wu, D. et al: H-V Interval in Patients With Bifascicular Block. Clinical, Electrocardiographic and Electrophysiologic Correlations, Am. J. Cardiol. 35:23-29, 1975.
31. Watanabe. Y.; Pamintuan, J. C. and Dreifus, L. S.: Role of Intraventricular Conduction Disturbances in Ventricular Premature Systoles, Am. J. Cardiol. 32:188, 1973.
32. Hasanain J.; Ashley, W. W.; Denes, P. et al: Effect of Exercise on Cardiac Conduction in Patients With Bifascicular Block. Circulation 48: Suppl IV p. 175, 1973 (abstract).
33. Kranz, P. D. and Haft. J. I.: Intraventricular Conduction (H-Q) Intervals During Orthograde Conduction in Patients With Complete Heart Block, Circulation 46 (suppl II):90, 1972.
34. Vera, Z.; Mason, D. T.; Ross, D. et al: Prolonged His-Q Interval in Chronic Bifascicular Block, Circulation 53:46-55, 1976.
35. Waters, D. D. and Mizgala, H. F.: Longterm Prognosis of Patients With Incomplete Bilateral Bundle Branch Block Complicating Acute Myocardial Infarction, Am. J. Cardiol. 34:1-6. 1974.

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Fasciitis (Eosinophilic) With Scleroderma-Like Changes in The Skin

John H. Talbott, M.D. and Benedict A. Cusani, M.D.

Case Report

Abstract: A case report of a relatively new syndrome identified in the current medical literature as fasciitis (eosinophilic) with scleroderma-like changes in the skin. Less than 25 cases have been described. Most of the patients are males. The characteristic features include firm induration of the skin of the upper arms and thighs and sometimes of the chest and abdomen as well. Deep biopsy shows normal muscle findings. However, inflammatory fasciitis usually with the eosinophils of varying degrees with changes in the overlying skin are seen. Symptomatic response to corticosteroids is rapid. Changes in the skin are much slower.

This is a report of a 57-year-old white male, active physically, whose activities were severely restricted when changes developed in the skin and subcutaneous tissues which had some resemblance to generalized scleroderma. There were no systemic symptoms usually associated with progressive systemic sclerosis such as hardening of the skin, muscle wasting, gastrointestinal disturbance or sclerosis of the myocardium or pulmonary tissue. Physical examination showed an orange-peel configuration, especially of the upper arms and thighs with limitation of motion of arms and legs. A deep skin, fascia and muscle biopsy showed diffuse inflammatory changes primarily in the fascia. No pathological changes were seen in the muscle and minimal changes in the skin. This patient, as others reported in the literature in recent months, responded to moderate and then small doses of corticosteroids. He died suddenly of a massive myocardial infarction more than 12 months after onset of symptoms thought to be unrelated to his disease or treatment.

Shulman et al[1] followed by Rodnan et al[2] has described a newly recognized syndrome of diffuse fasciitis, characterized by an elevated sedimentation rate, hypergammaglobulinemia and, frequently, an eosinophilia. It has been named the Shulman's syndrome by Caperton et al[3] to honor the original observer.

The clinical appearance superficially resembles the scleroderma of progressive systemic sclerosis or in some milder cases morphea, with induration of skin and subcutaneous tissues. The skin lesions are most evident on the arms and legs, less evident on the chest and abdomen. The face may be involved as well as fingers and hands. Shulman has stressed the characteristic orange peel-like configuration of the skin under tension. Caperton and Hathaway used the term "hide-bound." In some patients morphea-like patches may appear on the abdomen and become confluent. A skin biopsy which extends into underlying muscle bundles shows inflammation of the fascia, sometimes with predominance of eosinophiles. The inflammatory changes in the fascia are present in all cases. The overlying skin may show thinning of the dermis and areas of inflammation have been reported in adjacent muscle bundles.

We wish to report another case.

Report of Case

A 57-year-old white male of Irish-Lebanese extraction was first seen on March 24, 1975. The patient was a heavy participant in sports for more than 30 years beginning in his teens. In recent years the only physical activity in addition to his routine work as a barber was occasional swimming. At the age of 54, he reactivated his interest in tennis and began to play three or four times a week until the fall of 1974. At that time he noted an unusual stiffness in his legs after driving. More recently he experienced acute weakness at his right arm—"the strength in my right arm just gave out." Playing tennis became more difficult and the soreness and tightness in the muscles continued. By December, climbing a ladder was very difficult and playing tennis was a chore rather than a pleasure. Toward the end of December he had an eight-day siege of disseminated hives, a new experience for him. This responded to 20 mg./day of prednisone for one week. By March the skin of both arms and legs began to "thicken" which was readily apparent to the patient when put under tension. Roughness of the flexor surfaces of the arms and the inner aspects of the legs under tension with the appearance of the peel of a mature osage orange became evident. He continued his work as a barber but the increasing difficulty on motion prompted him to seek medical advice. There were no symptoms usually associated with pro-

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gressive systemic sclerosis such as Raynaud's phenomenon, pulmonary or esophageal - intestinal dysfunction or any clinical manifestations usually associated with any of the unusual collagen-vascular diseases.[5]

On physical examination there was slight induration of the skin of the flexor surface of the arms and legs (Fig. 1) when relaxed, beginning about 5 cm. below the curve of the shoulder and extending to 10 cm. above the wrist. In the legs the slight induration began about 5 cm. below the inguinal ligament and extended 5 cm. below the knee. On attempts at maximum extension, there was limitation of motion especially of the arms and the orange-peel (Fig. 2) configuration appeared with marked polka dot induration of upper and lower arms and to a lesser degree of the inner aspects of the thighs and the lower legs (Fig. 3). Maximum extension of elbows and knees was reduced by about 10 degrees at which point acute distress developed. Passive extension was equally distressing. The patient was unable to elevate the arms above the shoulders when extended (Fig. 4). When the arms were flexed slightly higher elevations could be achieved. There were symmetrical areas on the skin of the chest and lower abdomen also of orange-peel configuration but milder in appearance. The skin of the face, hands and fingers was normal. There was no limitation of motion of hands, wrists, or feet. Some distress on movement of the ankles was present. There was minimal weakness of the muscles of arms and legs.

With the clinical suspicion of systemic sclerosis or at least a "type of collagen disease,"[4] a skin and muscle biopsy was done over the biceps area, the site of maximum induration, as well as a number of x-ray studies. The erythrocyte sedimentation rate (Wintrobe) was increased to 48 mm. hr. The ANA factor was positive, 1 to 16. The latex fixation was nonreactive. The SMA profile was normal except for slightly elevated IgG globulin (2000 mg./100 ml.). The nonfasting glucose was 55 mg./100 ml. The chest roentgenogram was normal as well as the GI series, barium enema and IVP infusion pyelogram. The eosinophil count was 2%. The skin, subcutaneous tissue, deep fascia and muscle biopsy was interpreted initially as normal.

The patient was discussed informally in a teaching clinic at the Victoria Hospital, Miami, on May 21 and the possibility of Shulman's syndrome was entertained. The patient was examined again in the following days and the biopsy slides were reviewed. The recognition of inflammatory changes in the fascia (Fig. 5) was strong supportive evidence in favor of this diagnosis. The fascia between the subcutis and muscle was thickened with infiltration of plasma cells and lymphocytes both about and separate from the vessels. No eosinophils were seen. There was minimal thinning of the dermis, but the changes were not consistent with a diagnosis of scleroderma. No changes were seen in the adjacent muscle bundles.

The patient was placed on 40 mg. prednisone daily in divided doses and three weeks later this was reduced to 30 mg. a day. Symptoms slowly regressed with significant gain in spirits and body weight, attributed in part to the corticosteroids.

The last photographs were taken eight months after the onset of therapy. Almost full elevation of the right arm with maximum extension was achieved (Fig. 6) with slight but not acute distress as formerly. Elevation of the left arm was improved significantly. In a sitting position each leg could be elevated and flexed over the opposing knee without distress, a maneuver not possible except with the use of both hands formerly. There was also almost normal restoration of flexion of the ankle when the foot was resting on the floor. Under tension, no improvement in the skin of either arms or legs was evident.

At no time were there systemic symptoms other than noted. The patient continued to improve on gradually smaller doses of prednisone and eventually was maintained on 10 mg. a day. Suddenly on January 16, 1976 while at work and without warning he suffered a cardiac arrest, the rescue squad was called but he was dead upon arrival at the hospital. No autopsy was performed but the examining physician considered the death to be caused by a massive myocardial infarction.



Fig. 1.—Essentially normal appearing skin of the arm when flexed without tension.



Fig. 2.—The orange-peel configuration of skin from puckering of upper arm and forearm under tension with maximum possible extension.



Fig. 3.—Inner aspect of thigh of left leg under tension with orange-peel appearance.



Fig. 4.—Maximum elevation of arms and causing acute distress.

Discussion

This is probably a new syndrome, first described by Shulman in two male patients, ages 19 and 53 years old.[1] Each had a significantly increased number of eosinophils in the peripheral blood not attributed to the usual causes. Unusual physical exertion in the weeks preceding onset of the symptoms was noted. A few months later Rodnan et al[2] reported seven cases, five males and two females, ages 11 to 60. None had Raynaud's phenomenon nor any evidence of visceral manifestations of PSS. The eosinophil account ranged from 8% to 29% in four, the IgG was elevated in six and the biopsy showed eosinophils in the fascia.

Caperton and Hathaway[4] extended the series with five additional cases, ages 4 - 46. Spontaneous remission occurred in one of their cases. The response to prednisone was excellent. Shulman later increased his series[5] to include three males and one female, 19 to 58 years of age, and again stressed the precipitation of symptoms by unusual

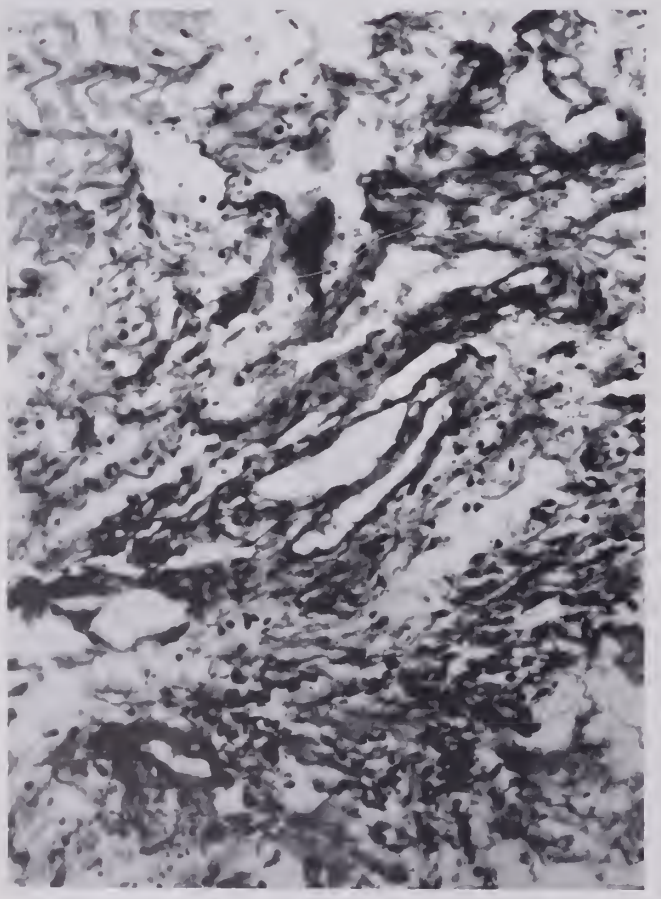


Fig. 5.—Photomicrograph of the panniculus and deep fascia with fibrosis and thickening, heavily infiltrated with lymphocytes and histiocytes.



Fig. 6.—Eight months later, normal elevation of right arm above head without distress, some restriction of maximum elevation of left arm (see Fig. 4).

exertion. One case has been reported by Schumacher, a 28-year-old male whose slow recovery took place over a span of more than three years.[6] Caperton et al in the most recent report has extended his series to 15 patients and emphasized the finding of variants of the original descriptions.[7] They noted that the eosinophilia may be very transient. Furthermore, the entire syndrome may recur months after withdrawal of steroids following an apparent cure.

The clinical findings in our patient were similar to most of the other cases reported, especially the character and distribution of the orange-peel induration. The laboratory findings were similar but not identical. They included an elevated gammaglobulin (IgG) and an elevated sedimentation rate. The biopsy showed thickening of the fascia with intense infiltration with plasma cells and lymphocytes, about and separate from blood vessels. A secondary characteristic of eosinophilia fasciitis, i.e., eosinophilic infiltration, was lacking. The biopsy of the skin showed slight atropy while the muscle fibers appeared normal. The tests for ANA, LE cell preparation and rheumatoid factors were negative.

Summary

This is one additional unreported case of fasciitis (sometimes associated with eosinophilia) and scleroderma-like changes in a middle-aged male, usually an athletically inclined person, whose symptoms responded to corticosteroids. It is the first case of a patient with this syndrome dying, most probably unrelated to the pathological state or treatment of same.

References

1. Shulman, L. E.: Diffuse Fasciitis with Hypergammaglobulinemia and Eosinophilia-A New Syndrome. Abstract No 82, VIth Pan-American Congress on Rheumatic Diseases, Toronto, June 16-21, 1974, in J. Rheum. 1:Suppl. 1, p. 46, 1974.
2. Rodnan, G. P., DiBartolomeo A.; Medsger Jr., T. A. and Barnes Jr., E. L.: Eosinophilic Fasciitis: Report of 7 Cases of Newly Recognized Scleroderma-Like Syndrome, Arthritis Rheum. 18: 422, 1975.
3. Caperton, E. M. and Hathaway, D. E.: Scleroderma with Eosinophilia and Hypergammaglobulinemia. The Shulman Syndrome, Arthritis Rheum. 18:391, 1975.
4. Talbott, J. H.: Collagen-Vascular Diseases. Grune & Stratton, New York, 1974.
5. Shulman, L. E.: Diffuse Fasciitis with Eosinophilia (abst.), Clin. Res. 23:443A, 1975.
6. Schumacher, H. R.: A Scleroderma-like Syndrome with Fasciitis, Myositis and Eosinophilia, Ann. Intern. Med. 84:50, 1976.
7. Caperton, E. M.; Hathaway, D. E. and Dehner, L. P.: Morphea, Fasciitis, Scleroderma with Eosinophilia — A Broad Spectrum of Disease. Ann. Meeting Am. Rheum. Assn., Chicago, June 10, 1976, Abst #40.

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My name, and my place, and my tomb, all forgotten,
The brief race of time, well and patiently run,
So let me pass away, peacefully, silently,
And be only remembered by what I have done.

—Bonar



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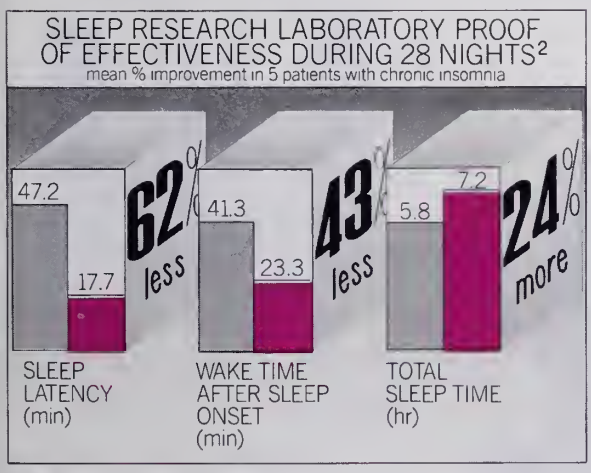

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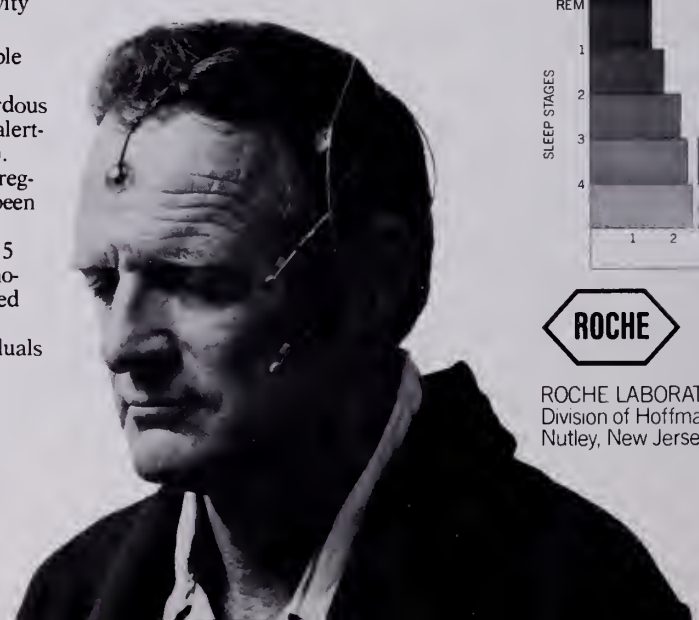
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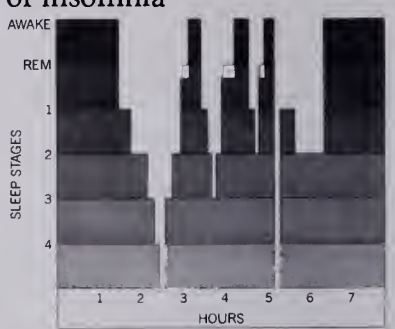
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REFERENCES:

1. Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975
2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
3. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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SPECIAL ARTICLES

The Educated Heart

Donn L. Smith, M.D., Ph.D.

Before addressing to you a few thoughts on this important occasion, let me share with you a paragraph from Sir William Osler's Valedictory Address at the University of Pennsylvania, May 1, 1899. Dr. Osler was one of the great physicians and medical educators of the not too distant past.

"To many the frost of custom has made even these imposing ceremonies cold and lifeless. To you, at least those of you present, they should have the solemnity of an ordinance — called as you are this day to a high dignity and to so weighty a charge. You have chosen your genius, have passed beneath the throne of necessity, and with the voices of the fatal sisters still in your ears, will soon enter the plain of forgetfulness, and drink of the waters of its river. Ere you are driven in all manner of ways like the souls in the tale of Er the Pamphylian, it is my duty to say a few words of encouragement and to bid you in the name of the faculty, God-speed on your journey."

Today it is my privilege to discuss with you— briefly—the origins and description of some of the qualifications that lead to the emergence of the great physician. Please bear in mind the very significant difference between "great," and good or above average. Among the characteristics of those whom we admire most in the profession of medicine are — devotion to duty — courage — vision — compassion, — and superior technical competence.

In the first analysis — the science of medicine requires on the part of the practitioner — fully developed and continuing competence in the techniques of medicine. This competence is brought to bear on the diagnosis and management of illness for any given patient — either in an episodic situation — or in the more comprehensive problems of continuing health care over a period of years. Proficiency in the science of medicine is a most necessary but strictly intellectually based ability. It is a matter, in the main, of sheer brain power effectively focused and accurately applied on appriate occasions to the clinical problem at hand.

It is generally agreed that scientific and technical competence may be learned, and that such learning is essentially a function of information storage, integration, and retrieval. Achievement in this specific area is possible for almost anyone of sufficient intellectual capacity — and is not significantly restricted to any group in terms of moral stature, integrity, race, religion or sex. Purely scientific medicine may be mastered and practiced without regard for another important part of medicine, known as the "art of medicine." The practice of purely scientific medicine may have brought to the profession the wrath of large segments of the public. It is clear that in the days ahead, there will be an increasing need for more effective practice in the art of medicine.

The central point here, and the basic purpose of this address, which is entitled "The Educated Heart," is to present to you the premise that great physicians do not engage themselves only in the practice of purely scientific medicine. The physician whose performance is clearly related to excellence, practices **both** the science and art of medicine. And it is the effective integration in practice, of the art and the science of medicine, which in my humble opinion ultimately resolves the relative greatness of any physician.

A successful and meaningful approach to the full understanding and application of the art of medicine, and its positive and necessary blending

This Commencement Address was delivered before the 1976 graduating class at USF by Dr. Smith, Dean of the University of South Florida College of Medicine, June 12, 1976.

with medical science, I believe, requires the education of the heart as well as of the mind.

I would again emphasize those qualities, **other than technical and scientific proficiency** which make the great physician so easily recognizable. We may consider, **devotion to duty,** which is a synonym for self discipline, or if you like just plain hard work and dedication and desire to excel; **compassion; courage;** and last but by no means least, **vision.**

These are generic and broadly based traits, which may result from a number of less well defined and variable intrapersonal resources — which underly the character and personality of most human beings regardless of occupation. But, in no endeavor, except possibly religion, are these underlying character forming elements of greater importance than in medicine. They may be learned, developed and strengthened for the most part, not always in the laboratory, lecture hall or by perusal of textbooks. In fact, it is perhaps unfortunate that so little of the modern educational technique is designed to facilitate this kind of learning and personal development.

Compassion is a form of humanity which will be evident to the least perceptive of your patients, and which may not be acted or feigned. This quality is an essential expression of an educated heart. Perhaps one individual may be more endowed in this manner than another. Yet, I believe we all have possession of the basic quality in some measure, and the extent to which it is expressed may be a function of environmental background which includes education and a particular culture. Perhaps genuine and true compassion is really a mirror for an inner security, a knowledge of one's own worth. A great physician is never reluctant to show tenderness and consideration to the weak and sick, pity for those who must suffer and charity towards all of his fellow men. To express compassion with probity, unclouded by maudlin sentimentality, is no easy virtue. That it must come from the heart cannot be denied.

Courage is perhaps the most admired human quality, and the expression and realization of your potential as a physician in full measure will require much courage. Loyalty to your profession and your colleagues, and ultimately to yourself, will make requisite the demonstration of courage on many occasions. To be true to your profession and all that it entails, to stand steadfast for what you believe to be right, may, on occasion, be exquisitely painful, to you and perhaps your loved ones. Even so, if you are to attain your full potential as a person and a physician, you simply cannot afford to deal in expediency, dodge responsibility, or in the slightest way discount your obligation to stand up for what is right and good.

I submit for your consideration, that we are speaking now of a learning process that may be described as "The Education of the Heart," and further that many of us hold to the sincere belief, that an essential characteristic of the complex and rare entity that we know as the **"Complete and Great Physician"** is the presence and expression of a well educated heart. Such an individual exercises an approach to the practice of medicine which is epitomized by the ability to transcend, rise above, and go far beyond that which is mediocre, expedient or simply acceptable.

Although it is not possible for me to present a full concise definition for every element of the truly educated heart, the qualities enumerated a moment ago are clearly recognizable as matters of the heart, at least in large part.

Devotion to duty, exercised as a form of self discipline must come from the heart. Those who develop and maintain the ability to achieve sustained and effective effort, do so by virtue of an inner conviction, and a deep personal drive in which cerebration plays only a small part. I do not imply that devotion to duty alone will assure renown or high esteem in medicine. In the words of Dr. Osler, "There is a struggle with defeat which some of you will have to bear," and I must remind you that devotion to duty is no guarantee against failure and defeat. Nevertheless, having expended full and consistent effort, even with disaster ahead and perhaps the loss of a patient imminent, this may be faced with some equanimity if you know within your heart that you have given of yourself in full measure.

In medicine, crises and pressures arise without prior notice. Once you have developed an overall strategy of courage, the day to day tactical expression of this trait is not terribly difficult. If you are to really deserve the privileged position which is yours as a physician, you must preserve and protect at any cost, your personal integrity, no matter how fearful the consequence or how high the stakes. In modern society, the physician cannot be considered to be uninvolved in community life, or privileged to rest securely barricaded behind the walls of the practice of medicine. Sooner or later each of you will be called upon by circumstance to make decisions relative to your fellow

human beings, in which your courage will be tested. Let us hope that everyone of you will be able to know in your own heart that you did what you thought to be right, without equivocation, without hesitation and without regret.

Another and less tangible characteristic of the educated heart is **vision.** The heart that can accept and nourish a dream, is a heart with vision. From such hearts in the medical profession over the centuries, gifts of great value have been given to mankind. Many such gifts represent the conversion into reality of dreams and visions of scientific and medical achievement. In fact, the high level of medical practice now possible is the totality of such gifts. The control of life threatening diseases, management of infections, repair and rehabilitation of those exposed to trauma and preventive medicine illustrate the point. It is sometimes difficult to maintain a sense of vision in the tumultous and exacting routine of the day to day practice of medicine. Even so the great physicians have always been people of vision, whose dreams and visions are today expressed in the very fabric of the medical education of which you are now the recipients. To cling to the appropriate sense of perspective and vision in the face of a cynical, materialistic and often outright hostile society will represent a most difficult achievement for all of us. If the basic image of the physician as we have known it, is to survive the onslaught of uninformed, and unrealistic public expectation and restrictive legislation, those who are members of the medical profession must continue to educate and strengthen their hearts towards vision and a sense of destiny. In this endeavor, courage and loyalty will be major elements in the struggle to preserve the hallmark of our profession. You must, as I know you will, develop and maintain forward looking attitudes.

Thus, we have for a few moments considered some of the characteristics of keystone importance, which are deeply involved in the edifice that is the great physician. And you may well ask how can all physicians be great, and I will answer that it is not the relative individual greatness that is so important, but that it is the continual pursuit of greatness by each of us that counts.

The knowledge of what is required, the expenditure of constant and informed effort, and a full measure of desire to achieve the best that is in you, is the essence.

Now at the very beginning of your careers, be appreciative of the rocky steepness of the road that lies ahead, learn of and study the difficulties that must be overcome, and with due humility accompanied by adequate self respect, recognize and learn to deal with the fallibility of your own talents and abilities. In the final analysis, this is one of the routes to greatness. To aspire in the first place, and to try to the maximum of your capabilities, to do the very best that lies within you, will put your feet on the right path. I am confident that many of you will choose the difficult and exacting pathway towards excellence and greatness.

In closing, with your kind permission, I take the liberty of quoting a bit of philosophy written by deGrillet which expresses in a most articulate way a thought which many physicians before you have found useful and inspiring, and which represents a fine creed for all people including the physician, "I shall pass through this world but once. If there be any kindness I can show, or any good I can do, let me do it now, let me not defer it or neglect it, for I shall not pass this way again."

▶ Dr. Smith, University of South Florida College of Medicine, Tampa 33620.

The worst sin toward our fellow creatures is not to hate them, but to be indifferent to them; that's the essence of inhumanity.

George Bernard Shaw

Sunshine Station — Florida's First Camp for Children With Asthma

Frederick L. Bloom, M.D., Dennis L. Spangler, M.D., Julia E. McMichael, M.D., Heinz J. Wittig, M.D., and Phyllis Upson, R.N.

Abstract: Forty-six children with asthma from throughout Florida participated in a camp experience for the first time in their lives. The camp was sponsored by the Florida Lung Association with the help of the University of Florida Department of Pediatrics. Because of the ready presence of nurses and physicians, there were no episodes of status asthmaticus in spite of there being 106 infirmary visits (about half for acute attacks of asthma) in the six days of the camp session. This initial camp session provided an otherwise unobtainable normal experience for these children with opportunity for personal growth in a safe setting, provided education for graduate nursing students, medical students, pediatric housestaff, pediatric allergy fellows, and an update in asthma therapy for some of the referring physicians.

At 10:30 a.m. on Sunday, August 17, 1975, an 11-year-old boy from Jacksonville arrived at Camp St. John to begin his first week away from home. What made this an extraordinary event was that this youngster has asthma.

Introduction

Significant asthma occurs in approximately 2.5% of the United States population. In 1964 it was estimated that 1.2 million school children suffered from asthma, accounting for about 25% of all school days lost due to chronic diseases and ranking asthma number one among the chronic diseases as a cause of school absence.[1] Having asthma in childhood is an abnormal physical, emotional, and social experience during this important developmental phase of life, and the maintenance of normal activity and a healthy self-image by the child are major goals in therapy.

Throughout the United States there are seven special camps for asthmatic children; none are located in the southeast.[2] The idea for a Florida camp originated with Dr. Robert H. Cohan while he was a fellow sponsored by the Florida Lung Association (F.L.A.) in the Division of Allergy and Clinical Immunology, Department of Pediatrics, University of Florida. The determination, organization, and financial underwriting were assumed by the F.L.A. as part of its new program area in pediatric lung disease, and they (P.U.), together with the medical director (F.L.B.), provided overall preparation and management for the specific needs of these children. The Division of Allergy and the Department of Pediatrics agreed to supply physician coverage. Both physician and nurse participation were entirely voluntary. Malpractice coverage was provided by the J. Hillis Miller Health Center group as this experience was viewed as a component of its overall training program for fellows, residents, advanced degree nursing students, and medical students.

The Camp

Sunshine Station activities took place at Camp St. John, owned by the Catholic diocese of St. Augustine and located in Switzerland, south of Jacksonville on the St. Johns River. The camp director, program director, counselors, dietary and maintenance personnel belonged to the Camp and most were vacationing college students. Once the site of the camp and the date of opening were agreed upon, local affiliates of the F.L.A. were informed of the program, brochures were prepared and distributed throughout the state, application and medical forms were prepared, and the selection process implemented.

From the Department of Pediatrics, University of Florida College of Medicine, Gainesville.

Tuition for the week was $100. A majority of the children were on "camperships" from local civic organizations, church groups, individuals, labor unions, and Lung Association affiliates. The camperships were solicited by the F.L.A. and its eight affiliates—the children and their families did not have to solicit aid directly.

Separate nonairconditioned cabins were available for the boys and girls. Plastic mattress and pillow covers were placed on each bed before the children arrived. Counselors slept in the cabins with the campers, and at least one counselor was available each night to transport by automobile any child in difficulty. The infirmary was located approximately one-third mile away from the cabins, in order to de-emphasize the medical aspects of the camp.

Campers

The campers were recruited by local affiliates of the F.L.A. through contacts with physicians, health departments, and respiratory disease educational programs throughout the state. Since the Florida camp was the first of its kind in the southeast, it was agreed that the number of campers would be limited to between 40 and 50, selected from throughout Florida without regard for sex, race, religion, or ethnic background.

Table 1.—Geographic Distribution of Campers

Location	Number of Campers
Belle Glade	1
Coral Springs	1
Daytona Beach (Ormond Beach)	4
Ft. Lauderdale	2
Gainesville	1
Holly Hill	1
Jacksonville	7
Lake Park	1
Lantana	1
Miami	4
North Miami Beach	1
North Lauderdale	1
Orlando	2
Palm Beach Gardens	1
Perry	1
Plant City	1
St. Petersburg	1
Sarasota	4
Sunrise	1
Tallahassee	4
Wabasso	1
Wauchula	1
West Palm Beach	4

Almost all of the children selected for the camp were on around-the-clock bronchodilators, and three children came to camp on chronic steroids.

The group selected for participation in the camp included 46 children, 30 males and 16 females, between the ages of seven and 13 years (Table 2).

Table 2.—Age Distribution of Campers

Age	Number of Campers
7	4
8	6
9	9
10	3
11	9
12	10
13	4

Program and Organization

All of the children were encouraged to participate as much as possible in the many activities available at the camp including football, basketball, swimming, and arts and crafts.

The infirmary included an outpatient room, a five-bed inpatient unit, bathroom, and sleeping rooms for the physician and nurse on duty. The infirmary was airconditioned and stocked with fluids for hydration. The unit was equipped and staffed to handle anything from minor complaints (many) to a respiratory arrest (none). Facilities for evacuation of a severely ill child were available should that procedure be required (it was not), a local hospital was available for minor, normal camp trauma (one), and University Hospital of Jacksonville was available for severe respiratory emergencies (none).

Medical coverage was around-the-clock, with one physician and at least one nurse available at all times in the infirmary, in the dining hall, or in the cabin area with radio communication to the infirmary. Physician coverage included two fellows in Allergy and Clinical Immunology (F.L.B. and D.L.S.) and a senior resident in pediatrics (J.E.M.) from the Department of Pediatrics at the University of Florida College of Medicine. A fourth year medical student visiting the University of Florida from Creighton University School of Medicine, Omaha, Nebraska was at the camp. He performed well on a free lance basis with children who had nonemergent problems, and in a medical capacity in the presence and under the direct supervision of one of the physicians.

Nurse coverage was provided by four graduate students in the Master's Program at the University of Florida School of Nursing and by the new director of the Master's Program in Respiratory Care Nursing. Initial guidance was provided by a nurse who had helped organize a similar camp in Minnesota.

Each child, or his family, was required to bring an eight-day supply of his current medications, properly labeled, for use at camp. Stock quantities of appropriate drugs were available in the event a medication was missing (one instance), or in case

a change in drug regimen was indicated. Drug regimens remained those that the referring physician had established, unless a child had difficulty and the medical staff deemed a change necessary. Medications were distributed in the dining hall before mealtime, at bedtime in the cabins, and during the night as necessary. All medications were handled by the medical and nursing staff, and no child was responsible for taking his own medication nor allowed to remove the medication from the infirmary. PRN medications were given only in the infirmary on physician's orders.

Before camp began, the medical staff met with the dietary personnel and removed the most allergenic foods from the weekly menu. A Kool-Aid type drink was the major fluid taken with meals and was available in the dining hall at all times.

Orientation sessions were held with the counselors and other camp staff to give instructions about asthma (the role of exercise, etc.), what to watch for, when to bring a child into the infirmary, and the importance of hydration. It was emphasized that these children were not and should not be treated as cripples but that many did have limits of exercise tolerance. We also reassured the counselors and alleviated their fears that the children were not prone to "dropping dead" as some of them had anticipated. A similar short session was held with the nurses, many of whom had seen in-hospital status asthmaticus but neither exercise-induced bronchospasm nor other mild to moderate attacks.

The Week of Camp

On arrival at the camp, the patients' history forms were reviewed, drug regimens confirmed, baseline peak flows obtained with a Wright Peak Flow Meter, and the children examined for signs of infection and respiratory status. A few children had to go straight to the infirmary for treatment, although none required inpatient admission. After check-in, the children reported to their cabins and had an orientation period on camp routine.

During the week of camp, each child participated in a broad range of activities intended to be enjoyable, teach new skills, expand abilities, and allow for participation in normal physical activity. Because swimming is the least asthmatogenic of the common exercises, this activity was greatly emphasized at Sunshine Station with at least two swims per day. Swimming is an exercise that many asthmatics have excelled at, including several gold medal winners in the Olympics.[3,4] Several discussion and question-answering sessions about asthma were held with the children in their cabins. Facts were given concerning the disease and the children were given an opportunity to discuss their disease and their feelings with physicians and peers.

When a child began to wheeze, he was brought to the infirmary, supplied with fluids, and given oral, nebulized, parenteral, or rectal (enema) medications as needed. The statistics on infirmary visits show that they were spread quite evenly throughout the week. This was an unexpected finding for we had anticipated an initial onslaught and a gradual tapering as the homesickness and newness of the experience resolved. During the week of camp there were 107 infirmary visits with 50 episodes of asthma, 10 gastrointestinal, 21 headaches, and 26 other complaints such as rashes and minor trauma.

There were no children with status asthmatics, no O_2 nor IV medications were required, and, as mentioned, there were no inpatient admissions. There were a few children with personal or emotional problems, and all of these children received time and compassionate understanding from the staff. One child had to be taken to a local emergency room after minor trauma for x-rays of a possible fracture.

The parents came to Sunshine Station on the last day to pick up their child, view the facilities, and talk with camp and medical personnel. On the final day, the medical director dictated a letter to each referring physician to relate the child's medical experience and to provide some continuing education for those physicians who were not allergists.

Postcamp

Postcamp questionnaires were completed by the parents, and they revealed that those who responded felt the camp experience was good for their child. About half the returned questionnaires indicated that some difference was noted in the child's behavior or attitude after the camp experience. Representative comments are as follows:

> ". . . gained a greater, tho (sic) subtle, self-confidence. My husband agrees."
>
> "He has never been away from home before and I know I am too protective of him."
>
> "He is better able to cope with his asthma now . . . he seems to have matured . . . he was able to relate to the children and wasn't out of place taking medication . . ."
>
> "Possibly more sociable."
> "He is more sure of himself."

Conclusion

Sunshine Station 1975 was a complete success—46 children had a unique experience not otherwise obtainable in the southeast.

Medically: The most impressive medical outcome of the camp was that although there were many instances of asthma, because of the ready presence of medical care which managed each case from its inception, there were no episodes of status.

Nonquantifiably: The overall outcome of the camp was that 46 children with a chronic disease which oftentimes does not allow the experience of a "normal" childhood without fear of wheezing in front of peers or fear of needing medical care if they go beyond their known limits were shown that they could participate in many normal activities. They gained this knowledge with a group of their peers with similar problems and were encouraged to go beyond their known limits because of the presence of a medical staff which was readily available to help them. This one-week session with separation from home and family could not have helped but increase each child's independence and self-esteem. The physical activity was a start in the improvement of general physical fitness for some of the youngsters who had been "crippled" by asthma, certainly improved the quality of their lives, and gave them a more positive attitude toward themselves.[5]

Educationally: The children benefited by having myths and fears dispelled, which hopefully they will carry with them in the education of their families and others. The graduate nursing students found it very valuable to observe and get to know children with a chronic disease that has many facets. The physicians learned a great deal regarding exercise, emotions, medications, and asthmatic children in general. It is hoped that the letters to the referring physicians helped to spread knowledge regarding methylxanthines and other aspects of asthma therapy.

Some of the children (as always) expressed their satisfaction with Sunshine Station best when relating just before departure that they had been "homesick" when they first arrived but now were sad about leaving and would be "campsick."

Acknowledgements

Special thanks to Merle Scherr, M.D. for the opportunity to learn about asthma camping, and to the many drug companies and representatives who donated supplies.

F.L.B.

References

1. Patterson, R.: Allergic Diseases, Diagnosis and Management. Philadelphia, J. B. Lippincott, 1972, pp. 198-199.
2. Reference list of "Institutions and Camps for Asthmatic Children-1971," American Academy of Pediatrics.
3. Fitch, K.D.: Comparative Aspects of Available Exercise Systems, Pediatrics 56:Suppl:904-907, 1975.
4. Fitch, K.D.: Exercise-Induced Asthma and Competitive Athletics, Pediatrics 56:Suppl:942-943, 1975.
5. Scherr, M.S.: Camp Bronco Junction—Second Year of Experience, Ann. Allergy 28:423-433, 1970.

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Addendum: Since this article was submitted for publication Sunshine Station 1976 has been successfully completed, accommodating 86 asthmatic campers from Florida from July 2nd through July 10th, 1976. We hope to continue this activity in future years.

A NEW PLEDGE OF ALLEGIANCE. **from Joe Butterfield, M.D. "I pledge allegiance to the Secretary of HEW and to Public Law 93-641 for which he stands, one health system for all, divided into 202 HSAs and 203 PSROs with bureaucratic opportunity for all."**

Drug Substitution Law
Committee Substitute for HBs 2740 and 2950

Jack A. MaCris, M.D.

Florida physicians are facing a confusing and difficult situation as a result of the new drug substitution law passed by the 1976 Legislature. This law requires pharmacists to substitute a less expensive generically equivalent drug product for the drug physicians prescribe, unless the physician expressly forbids it. Drug substitution could soon become the norm throughout the State. The law directs that each pharmacist follow his own discretion when it comes to determining equivalence—each pharmacist will be making up his own list of interchangeable drugs, limited only by a State listing (Negative Formulary) of a certain small number of drugs deemed not equivalent.

Carte blanche drug substitution under the new law is allowed. To insure the drug product you select is filled by the pharmacist, you will have to write **"Medically Necessary"** in your own handwriting on the prescription form every time you prescribe a particular brand of a multi-source product. Otherwise, as the law requires, your patient will not get the product you have prescribed, but rather the pharmacist's choice of an equally effective product.

Substitution is not a new idea — we have been hearing about it for over a decade now, and it's been tried in two dozen jurisdictions in North America. Florida consumers are being asked to believe that they will be getting drugs of equally high quality —when in reality what they will be getting won't be the best, just less expensive. They are also being asked to believe that they will save some $40 million as a result of passage of this law.

The whole idea behind this legislation is to save consumers money by requiring the use of less expensive drugs; however, there is considerable doubt that the savings will be anywhere near the amount expected by the law's proponents.

Where does all this leave the physician? In a quandary. Responsible patient therapy requires that the physician have the most complete control possible over all the variables in treatment. Yet, this legislation diminishes the doctor-patient relationship and limits his control over one of the most crucial factors in therapy — drug selection. The doctor may write "medically necessary" on his prescriptions, but this is cumbersome and may be easily overlooked in the rush of practice; additionally, the complexities of this new law are such that many physicians may remain unfamiliar with or unaccustomed to this provision of the law. Furthermore, the present estimate by the Regulatory Boards is that promulgation of the negative formulary to restrain a pharmacist from substituting clinically significant non-equivalent products will not occur until about the end of the year. In the meantime, drug substitution is legal and widespread with no limitations or protections.

The present law does not require the pharmacist to notify the physician of any substitution made, however, the language in the law does protect the physician against liability for drug substitution. The law requires the Board of Pharmacy and the State Board of Medical Examiners to establish a negative formulary of drugs which are not demonstrated to be therapeutically or biologically equivalent, thus prohibiting substitution of drugs in this formulary. Public hearings are scheduled to be held on the rules and regulations to implement this law August 27 in Miami at the Americana Hotel and in mid-September in Orlando. FMA will have representation present at both hearings and will continue to monitor the implementation of this law.

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Notes on Russian Psychiatry

Philip B. Phillips, M.D.

A recent visit to the Soviet Union in company with a group of 160 psychiatrists and wives revealed some interesting aspects of Russian psychiatry.

There are 82 University Medical Schools in the Soviet Union. Three are in Moscow. Each of these three graduate 15 or 16 third year residents in psychiatry annually. Medical schools have a six year program with three years devoted to premedical study and three years to clinical work. Medical education is popular in the Soviet Union as in the United States and the percentage of the population who are physicians is much higher than in our country. Eight or nine doctors per 10,000 people is the average for Florida communities while there are 38 doctors per 10,000 people in Armenia and 37 per 10,000 in Georgia and the Ukraine. The Medical Institute in Yerevan, Armenia, has 6,000 students. After graduating from medical school students have two career options. They may go out into general practice or if in the selected few they may stay in a university or hospital setting for a one year internship or residency in a specialty of their choice. After this one year of specialty training they are required to do two years of duty in a community as a partially trained specialist and general practitioner. After they have been out of school three years they may compete for specialty training and if accepted will do three years of residency training in their chosen field. If a graduate should choose to specialize in psychiatry, a subject which was introduced in his fifth year of medical school, he must during his three year residency period write a thesis which is similar to that required in a Master's Degree program in graduate school. Upon completion and acceptance of this work he will become a Dozent or the equivalent of a Board Certified Psychiatrist in the United States.

Seventy to eighty percent of the doctors in Russia are women, but few of these go on to specialization because after such training they might be assigned wherever the government wanted them and thus separated from their husband and his job.

Hospital Care

There are 80 state supervised psychiatric hospitals in the U.S.S.R. and all of these conduct graduate training programs. There are 3,000 dispensaries or polyclinics scattered throughout the Soviet Union; 150 are psychiatric dispensaries each staffed by some 15 or 20 psychiatrists and nurses. Usually there are two outlying psychiatric dispensaries for each of the state hospitals. Research is emphasized in each of the major hospitals and programs involving genetic, biochemical, psychosomatic, and therapeutic research are ongoing. Most of the hospitals are old but spotlessly clean and well staffed. The physicians were conversant with American literature and reported that they read European and American literature regularly. The Senior Physician of one hospital was a 75-year-old academician and his assistant, a man in his 60s. Each physician on the staff is responsible for about 20 patients. In a 500 bed hospital in Armenia there were 20 staff physicians and 19 residents. The Chief of Surgery had recently retired at the age of 80. A 300 bed psychiatric hospital in Tbilisi, Georgia, was full and some patients were sleeping on the floor. The staff physicians showed much interest in what was going on in psychiatry in the United States and asked many questions about our methods of treatment. They were not interested in the newly developing field of family therapy believing this was a social and not a medical problem. A hospital in Kiev for both children and adults had women physicians on the children's side and male physicians on the adult side. Hospitals seem adequately staffed with nurses. Teachers and psychologists are on the staff of children's hospitals but psychologists do not work in dispensaries or adult type hospitals since physicians believe psychologists are best suited for work in schools and social agencies.

Usually patients are seen first in the dispensary and sent to the hospital for treatment when such

is believed to be necessary. These patients are evaluated by the hospital staff within 24 hours and if the staff does not believe the patient needs hospitalization he is promptly discharged. It is said that about one third of the patients sent to the hospital are referred back promptly to the clinics as not requiring hospitalization. Doctors and nurses who work in the polyclinics make 20 home visits a month to see that their patients are adjusting well, taking proper medication and that the family is providing adequate care. Children's clinics and adult outpatient clinics keep careful records on the patients and these are available only to physicians who are treating the patients later in the hospitals. Confidentiality of records is emphasized.

Psychiatric patients are generally hospitalized from two to four months and then returned to the outpatient clinics for follow-up. If the patients remain in the hospitals for six months their records are reviewed to determine if further hospitalization is needed. In the hospitals treatment consists of psychotherapy, insulin therapy with dosages from 15 to 100 units daily during such treatment and electroshock is used for involutional depression. Electro-sleep is often used in treating children. Work therapy is emphasized from a social standpoint. Both the hospitals and the clinics use the currently accepted drugs such as trifluoperazine, amitriptyline, haloperidol, and the thioxanthenes. At several different hospitals we were told that delinquents or psychopaths are not considered as medical problems. Delinquent adolescents are put to work or in jail, but not hospitalized. At the hospital in Georgia it was reported that Ergotherapy is best for adolescents, that is, youngsters are put to work and made to work to control their antisocial tendencies. Work therapy is considered meaningful and adult patients who are capable of gainful occupation while in the hospital are paid for the work they do. A physician's prestige is high and he may recommend to an employer that a patient's duties be increased or decreased according to the patient's illness and his abilities.

There are 14,000 psychiatrists in the Soviet Union. These people staff the universities, the state supported hospitals and the many outpatient polyclinics. They also work in the various research institutes associated with the hospitals. Each physician on the staff of a hospital is responsible for about 20 patients. A hospital psychiatrist may be sent to a general medical or surgical hospital to do a consultation on a disturbed patient and arrange transfer to the psychiatric hospital. If a patient becomes acutely psychotic at his home the psychiatric hospital sends an ambulance and psychiatrist to bring the patient into the hospital. Doctors who are working in the psychiatric clinics are expected to go to the large hospitals for postgraduate training of five months duration every five years.

Retirement and Income

In the Soviet Union male physicians may retire at age 60 and female physicians at age 55. After retirement many take other jobs and they may continue working if they wish. Doctors' salaries range from 200 to 400 rubles a month. A ruble which formerly had a quoted value of $1.11 had increased in value, we were told, to $1.31 and it was at this rate that exchange was made. However, black market rubles were readily available in any large city at a rate of 67¢ per ruble. Exchanging money at any place except a government run bank was strictly forbidden with severe penalties threatened. Intourist guides report that the ruble is not a convertible currency and is recognized only in Egypt and these guides added that this is the reason Russians do not travel outside the Soviet Union to any appreciable degree. We were told that raises are possible at the end of five, ten, and 15 years of service and are given to those the government feels merit such raises. At a mental hospital the Superintendent may after many years of work reach a salary of 600 rubles a month. To give some idea how this compares with other salaries we learned that school teachers earn approximately 140 rubles a month, Class I truck and bus drivers earn 240 rubles a month, while hall girls and clerks in hotels generally earn about 70 rubles a month if regularly employed on a 40 hour week or three rubles a day if working part-time. To get some impression of the relative value of the ruble we learned that rents were very cheap with apartments renting at $8.00 to $15.00 a month with utilities included. Food is quite high and butter was quoted at $1.75 per pound. Dress goods in the department stores were very high. A small piece of synthetic material was quoted at nine rubles per yard for 36 inch material. Transportation seems cheap with a streetcar ride being three kopeks and a bus ride four kopeks. This is approximately 5¢ in American money.

Level of Practice

More than 70% of the psychiatric patients in the Soviet Union are females. Schizophrenia is said to be a greater problem than manic depressive illness. Oligophrenia or mental retardation is a source of great concern. The attitude toward alcoholism

varied from country to country. Several physicians stated they did not consider alcoholism a psychiatric problem, but rather a social problem. Alcoholics are put in jail overnight and sent back to work the next day. One physician reported that in Hungary alcoholics reported to a clinic once a month to take a drink and have an Antabuse reaction to prove they were faithfully taking Antabuse. If they did not have such a reaction they were disciplined. At this hospital in Tbilisi we were told the staff had used Antabuse successfully with alcoholics, but had run out of it and thus had to quit using it.

Russian psychiatrists have no particular appreciation for Freudian psychoanalytic concepts but do admit that neuroses are not altogether biologically inherited. They prefer to look upon such reactions as a reflection of inner conflicts with outer reality. They indicated they understood biofeedback, but were not particularly interested in it. Electro-sleep was being used at the children's hospital in Kiev in an effort to calm the disturbed behavior of the children and habituate them to an afternoon nap. Children in this particular hospital were said to be victims of childhood encephalitis or meningitis and some had minimal brain dysfunction. Others were epileptic and some were mental retardates. There were juvenile schizophrenic and autistic children in the patient group.

It was the impression of the American psychiatrists conducting this visit that the level of psychiatry being practiced in the Soviet Union at this time was reasonably comparable with that in the United States since the staff men appeared to be well trained and to have adequate psychopharmaceuticals, competent nurses and it appeared the rights of the patients were respected. We did not question them about political dissidents since this has been a source of conflict between Russian psychiatrists and those of the western nations. It appeared to us as visitors that such detention of protesters against the government was not a function of the psychiatrists themselves, but rather the political system and resulted from dictation from higher political figures. The author has visited psychiatric facilities in 11 different countries and at the present time it appears that treatment provided mental patients is at least adequate in all these different countries though it lacks many of the refinements of American psychiatry.

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Tampa Bay Medical Library Network Is Organized

A Tampa Bay Medical Library Network (TABAMLIN) has been organized to provide immediate delivery of information to the health science community of Pinellas and Hillsborough Counties.

Thirteen institutions are participating, and TABAMLIN Chairman Marianne Hough of Tampa said the network has arranged coordinated binding, completed a list of journals and begun plans for cooperative acquisitions. Central office will be located at the University of South Florida Medical Center Library under Fred D. Bryant as Director of the Library, he is the principal investigator for a grant to be submitted to the National Library of Medicine for funding the network.

Participating institutions are: Florida Mental Health Institute, Tampa General Hospital, Tampa Veterans Administration Hospital, University Community Hospital, University of South Florida Medical Center Library, and Hillsborough Community College, all in Tampa; All-Children's Hospital, Bayfront Medical Center, St. Petersburg Junior College, and Bay Pines Veterans Administration Hospital, all in St. Petersburg; Morton Plant Hospital, Clearwater; Mease Hospital and Clinic, Dunedin; and South Florida Baptist Hospital, Plant City.

The Changing Image of Medical Education in Brazil

James J. Cerda, M.D. and Emilio A. Francischetti, M.D.

Abstract: Medical education in Brazil has been patterned, in the past, along conservative, European lines. Changes in this attitude are described at the medical school located in Sao Jose do Rio Preto, Sao Paulo. This institution is an example of a Brazilian medical school which is attempting to (1) shorten and integrate the curriculum, (2) raise admission standards, (3) acquire full-time faculty, and (4) introduce new teaching techniques. Other Brazilian schools are also reorganizing curriculae, with an emphasis on primary care. Further changes in approaches to medical education in Brazil can be expected.

Medical education in Brazil has had a long and interesting history. During the colonial period (1500-1808) no medical schools were established. Students were trained at European universities, primarily Coimbre University, Portugal. The first school of medicine was established in 1808 in Salvador, the first capital of Brazil, now the capital of the state of Bahia. The founding of this school was coincidental with the arrival in Brazil of the Royal Portuguese Family, a historical consequence of the Napoleonic Wars. From 1808 to 1910 only three other schools were established. During the next decade, six additional schools were founded. In 1920 the first Brazilian University was founded in Rio de Janeiro. Classes were small and made up almost solely of wealthy students. Upon graduation, the young physician generally stayed in the large cities and ministered to those who could afford medical care. Therefore, there was both an inadequate number and an unsatisfactory distribution of graduate physicians. This situation remained largely static until 1965 when the Brazilian government supported proposals to increase the number of medical schools throughout the entire country. From 1965 to 1972, 38 new schools received legal authorization to commence educational activities. This rapid growth entirely modified educational perspectives, at least in terms of quantity. For example, there were 51,709 medical students in 1974 as compared to 21,907 in 1967. At the present time, there are 73 schools of medicine in Brazil and 74 courses on medicine. Sixty of these institutions have already graduated students and are officially recognized by the federal government. Most of the new schools have received the major portion of their financial support from private sources, although the federal and state governments have made substantial contributions. With this rapid growth, the quality of medical education has suffered since the benefits of this rapid development of schools has not been paralleled by a proportionate increase in the number of teachers. The schools have, therefore, been staffed primarily by part-time faculty members engaged in active practice. The student/full-time professor ratio is approximately 7:1. Frequently, many of the smaller medical schools are, by necessity, staffed by physicians from the more prestigious schools at the larger cities, such as Rio de Janeiro and Sao Paulo. These physicians must travel as much as 200 miles to spend two to three hours per week to teach students at the smaller schools.

In 1968 the School of Medicine of Sao Jose do Rio Preto was established with the major objectives being (1) the acquisition of a full-time teaching faculty and (2) the establishment of an integrated curriculum — a major departure from previous policy.

The school of medicine is located on the southern outskirts of the city of Sao Jose do Rio Preto, which has a population of approximately 150,000 and is situated in the western part of the state of Sao Paulo. Although it is slightly larger, Sao Jose do Rio Preto resembles Gainesville, Florida. Likewise the medical school complex bears a structural resemblance to the University of Florida College of Medicine. The city and its immediate surrounding communities produce a population of approximately 1 million. Three hundred miles to the southeast is

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Sao Paulo, the largest city in Latin America and 500 miles to the northwest is Brasilia, capital of Brazil. The area is one of the most important regions for the production of coffee, sugarcane, cattle and citrus. Major industry has been attracted to the area. For example, one of the world's largest hydroelectric stations is located 100 miles west of the city, having a potential of 4,500,000 in numbers of kilowatts. Existing hospitals contain approximately 1,000 beds. This includes a regional center for cardiac investigation and cardiac surgery, and a sanitorium for tuberculosis with a tuberculosis inpatient unit. Prior to the building of the teaching hospital, indigent care was primarily carried out at the Casa de Misericordia, a Catholic hospital which is still the largest hospital in the city with 400 beds.

Approximately 50% of the population contribute to the National Institute for Social Welfare managed by the federal government. The critical shortage of physicians in the area as well as the gross potential of the area also played a major role in the founding of the School of Medicine of Sao Jose do Rio Preto. Consequently the Ministry of Education favorably supported a proposal to establish a medical school in Sao Jose do Rio Preto in February 1968. Financial support for the school came from FRESA, a regional foundation, which held the responsibility for maintenance and development of the school. The state government then agreed to contribute to this organization a sum greater than that which the participating cities contributed to the foundation budget. It was anticipated that the students would support approximately one tenth of the total cost of their education.

Foundation and Particular Features of the School

In April 1968, the Regional Foundation appointed the first Dean, Dr. A. Ribeiro, whose initial appointment was the Professor of Anatomy, Dr. H. Werneck. Much of the early planning and organization of the school was their task. Later in 1968 and in 1969, Professors of Histology and Microbiology were appointed. The clinical teaching began in May 1970 with appointment of the Professor of Medicine and his attendant responsible for 50 medical beds. By 1972 the School of Medicine had the equivalent of 25 full-time teachers, 12 of whom had received postgraduate training in the United States, England, Belgium, or Sweden. Since then Professors of Psychiatry and Gynecology have been appointed who have half-time responsibilities.

The Medical Curriculum

The curriculum was formulated by the Committee on Education, and contained members from all departments as well as two student members. Initially, the curriculum was planned for six years, each year having 38 weeks of study. However, this has been modified in an effort to combine the two final years as a "pre-internship" year with major rotations in medicine, surgery, obstetrics, gynecology, and pediatrics. The phases of the curriculum were planned by subcommittees assisted by departmental chairmen. Special emphasis was placed on integration of the curriculum. Major teaching techniques which have been used have included (1) tutorials, (2) programmed texts on medical education, (3) group discussion employing group dynamic techniques, (4) slidetape lectures, (5) films, and (6) formal lectures.

In the first year the students receive courses in anatomy, histology, psychiatry, and psychology. In addition to these conventional courses, the students begin their initial visits to the hospital and have brief contact with some of the clinical teachers and nurses.

The second year is devoted to biochemistry, biophysics, physiology and pharmacology. The physiology department has attempted to integrate a portion of its teaching with the clinical departments with some success. Unfortunately, there is a shortage of well-trained personnel in biochemistry. This has necessitated that the teaching of biochemistry be done by the Biochemistry Department from the Federal University of Minas Gerais, Belohorizonte.

In the third year the students begin courses in general pathology and microbiology. Advanced pathology is taught in the fourth and fifth years in parallel with the main clinical subjects.

Clinical clerkships also begin in the third year. The students are introduced to problem-solving and the techniques of history and physical examination. During this period, pathophysiology is emphasized and the students are divided into groups of two's to three's to see individual patients. Student workups are reviewed by a preceptor and group discussion is emphasized.

The clinical clerkship is continued into the fourth year which is run primarily by the Departments of Medicine, Surgery, and Preventive Medicine. Each student rotates for 12-week periods on the wards, in the outpatient clinic, and in a program of Family Medicine. A major portion of the program

in Family Medicine is accomplished at a nearby community of approximately 30,000. During this period, the students are assigned to practicing physicians with a primary interest in family practice and public health. Clinical teaching at the teaching hospital and affiliated hospitals continues with an emphasis on case presentations and on individual growth by the student. Neurology, ophthalmology, otolaryngology, and urology are introduced and, at present, are taught by part-time teachers under the supervision of the full-time staff in medicine and surgery. There has been a great deal of interdepartmental collaboration in the teaching and a remarkable enthusiasm for this particular portion of the teaching program by the students.

Students in the "Internship" Program

In the fifth year the students begin their rotating "internship" program. Twenty-two weeks are accounted for by the Departments of Medicine, Surgery, and Preventive and Social Medicine. Students are urged to continue following their patients in a home-care program after the patients have been discharged from the hospital.

Extremely good relationships have been maintained with outside private physicians in the city. Many of these physicians made up a portion of the part-time staff. The students have, likewise, cooperated whole-heartedly in the teaching arrangements. There appears to be no "town vs. gown" feeling. In addition, the community, as a whole, and the patients have been quite enthusiastic and proud at having a medical school and hospital so readily accessible.

Selection of Students

There are approximately 1,000 applications per year for admission to the medical school. The average age of the applicants is 18. The basic prerequisite for entrance to the first year class is success in the university examinations. The student must take a multiple-choice examination in cell biology, chemistry, physics, English, and social psychology. Having passed the examination, his name is referred to the selection committee where he is asked to demonstrate his knowledge in animal dissection, zoology, chemistry, cell structure and function. Because of the general feeling of the faculty that premedical education (the equivalent of the European "gymnasium") is lagging in the area of biological science, the admitting policy has been rather strict. There are only 64 positions in the first-year class.

The Teaching Hospital

The main base for the medical school operation during the clinical phase is the 400-bed teaching hospital. At present, only one half the beds are in use due to staffing shortages. There are continued attempts to gain more space, primarily for teaching and research. In 1969 the School of Medicine received a donation from the federal government which consisted of equipment from West Germany and Hungary, total cost of which was estimated at approximately 1 million dollars. A significant amount of this equipment is of rather modern vintage and research projects have been undertaken primarily in the field of parasitology with an emphasis on Chagas' disease and in the areas of preventive medicine.

Discussion

It appears that within a relatively short period of time the Medical School of Sao Jose do Rio Preto has organized an excellent base from which it continues to expand. It is particularly noteworthy that actual teaching commenced two years after appointment of the Dean. The strength of the program has been the emphasis on curriculum integration, hiring of a full-time faculty, and small classes. Elective periods for students have been added. There is an avoidance of formal examinations, and emphasis has been placed on regional pathophysiology. The faculty has taken an active interest in assisting the students with their postmedical school planning. There has been a gratifying emphasis on preventive and social medicine, behavioral science, and the relationship of the medical school to the community. The shortening of the curriculum to five years is a totally new experience as regards to the standards of Brazilian medical education. An attempt is being made to analyze the results of the impact of this change. One thing can be said: the students have been quite enthusiastic with the program and it is obvious that they are able to acquire the understanding and technical competence in the shorter period of time.

One of the major disadvantages has been the paucity of research. The enormous teaching load and the small staff have precluded an expanding research program. Because of the extremely close relationship between the students and the full-time faculty; however, there have been a number of small projects initiated by the students which are enthusiastically pursued.

It should be noted that other Brazilian schools of medicine have also been reorganizing their curricula, particularly toward improving delivery of primary care. This emphasis on primary care is appropriate since the estimated population of Brazil will reach 110,000,000 this year and only in urban areas has there been a high index ratio of physician/patient. In order to more fully examine this and other future problems, the Brazilian Association of Medical Schools (ABEM) held its 13th annual session in October 1975. A considerable part of this meeting was devoted to discussing medical education and delivery of ambulatory care medicine with particular emphasis on primary health care, the team approach to primary health care and comprehensive care. It is noteworthy that the School of Health Sciences of the University of Brasilia (D.F.) had developed in 1966 a model of primary care in rural communities separate and distinct from the teaching hospital. Besides the School of Medicine of Rio Preto, other teaching institutions such as the School of Medicine of Londrina (Parana State), the School of Santa Casa de Misericordia [Sao Paulo State (SP)], the School of Medicine of Federal University of Minas Gerais, and the Medical Sciences School of State University of Rio de Janeiro have replicated with some modifications the Brasilia model of primary health care.

More recently, the School of Medicine of Taubate (SP) has oriented its academic program to the teaching of family and community medicine and the School of Medicine of Jundai (SP) has commenced a primary health care model utilizing nurse clinicians.

It would appear, therefore, that there is a substantial effort in Brazil to break away from older traditional methods of medical education. Further changes can be anticipated.

Acknowledgements

The authors are indebted to Drs. L. E. Cluff, R. C. Reynolds and J. E. McGuigan for review of the manuscript, and to Dr. F. Bevilaqua, Executive Director, Associacao Brasileira de Escalar Medicas, for kindly providing much of the historical data.

▶ Dr. Cerda, Division of Gastroenterology, Box J-214, J. Hillis Miller Health Center, Gainesville 32610.

Research Grants for 1976-1977 Accepted Until October 30th. The Florida Medical Foundation Committee on Research will accept applications for 1976-1977 research grants until October 30th. Applications and other information may be obtained by contacting J. Lee Dockery, M.D., Chairman, Committee on Research, Florida Medical Foundation, P. O. Box 2411, Jacksonville 32203. Recipients will be announced early in 1977.

FMA SPECIAL MEETINGS, SEPTEMBER 1976

FMA will hold special meetings during the month of September at the Host International Hotel in Tampa on several topics of major importance and interest.

Sat., September 11—(9:00 a.m. - 5:00 p.m.) and **Sun., September 12**—(9:00 a.m. - 12:00 noon) (Host International Hotel, Tampa—West Grand-ballroom)

Conference on Identification of Needs and Standards of In-Hospital Critical Care—The Florida Medical Foundation will sponsor, through a grant from the Emergency Medical Services Section of the Health Program Office, a multidisciplinary Conference on the Identification of Needs and Standards for In-Hospital Critical Care.

During the day and one-half long Conference, categorization of in-hospital critical care will be considered. 1. Major trauma; 2. Cardiac and general medical emergencies; 3. Burns; 4. Head and spinal cord injuries; 5. Neonatal, and 6. Psychiatric, poison, drug and alcohol.

Major emphasis will be given to the development of a method to profile in an objective and fair manner the critical services offered by hospitals. Representatives from county medical societies, specialty groups, allied health professions, hospital administrators, and voluntary health agencies are encouraged to attend.

Sat., September 11—(1:00 p.m. - 5:00 p.m.) and **Sun., September 12**—(9:00 a.m. - 12:00 noon) (Host International Hotel, Tampa—East Grand-ballroom)

The FMA, the FMA-PLI-Trust, and the Professional Insurance Management Company (PIMCO) will sponsor a seminar on recently enacted professional liability legislation and risk management. Attendance is by invitation and advance registration only. Discussions will center around recently enacted PLI Legislation and its implementation including the risk management portion of the legislation and the newly created medical incident committees. Mediation panels will also be discussed as will the new risk management consultant services to be offered by PIMCO.

Sat., September 25—(9:00 a.m. - 5:00 p.m.) and **Sun., September 26**—(9:00 a.m. - 12:00 noon) (Host International Hotel, Tampa—Grandball-room)

The FMA will sponsor a Public Relations Seminar for county medical society officers, public relations chairmen, executive directors, and Auxiliary presidents. The Seminar is specifically designed to provide basic public relations techniques and programs and also more advanced training for county medical societies.

The Conference is being held as part of FMA's public relations thrust and in response to requests from county societies for basic and advanced presentations in public relations.

For additional information on these special meetings, you may contact the Florida Medical Association, Inc., P.O. Box 2411, Jacksonville, Florida 32203 (904) 356-1571.



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* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

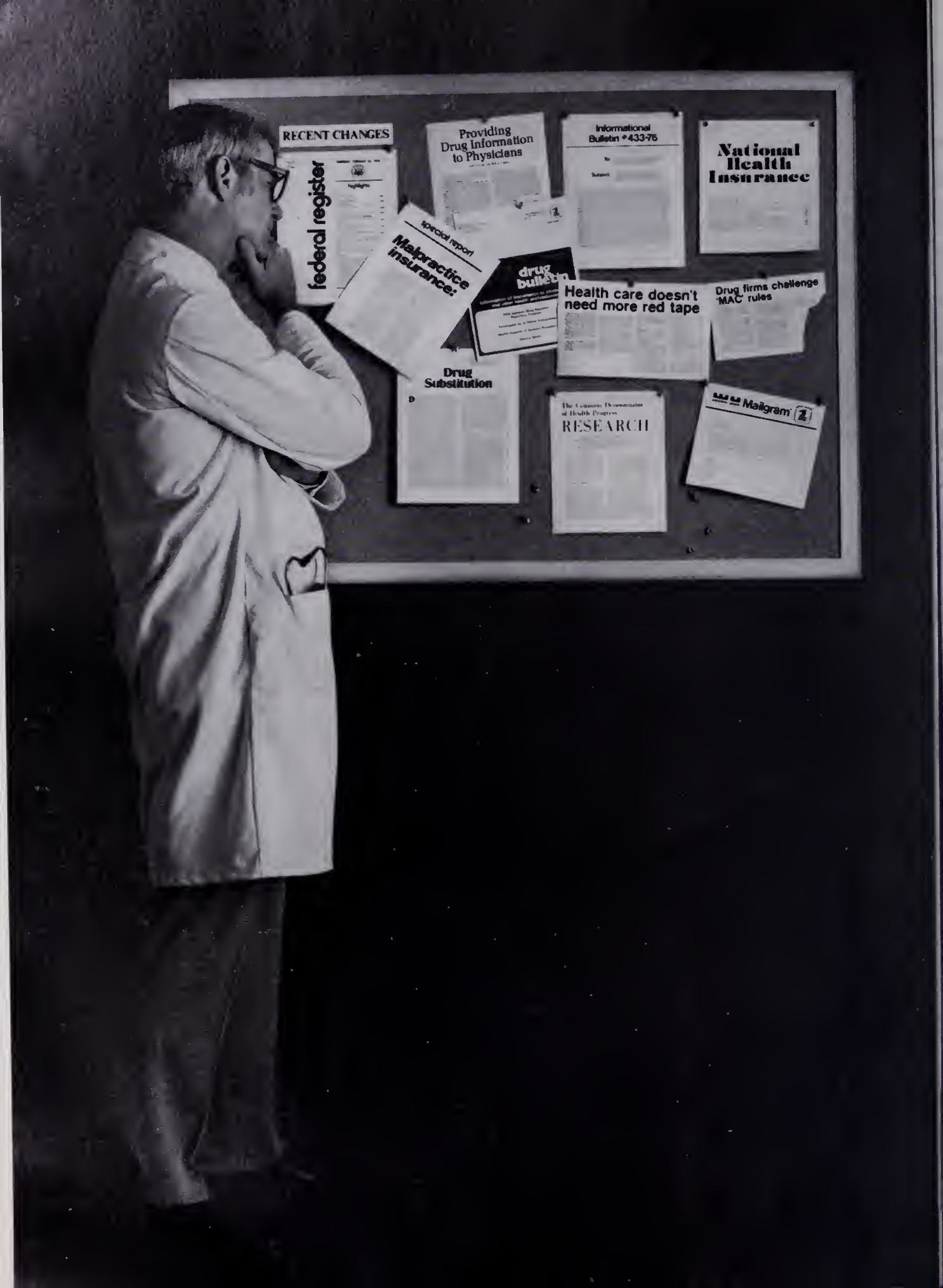
Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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ORGANIZATION

Two FMA Members Honored





Two Florida physicians were presented with the coveted Presidential Award during the annual convention of the Florida Heart Association at Innisbrook on May 29. Recipients of the award, only five of which have been presented in the quarter-century history of FHA, were Jere W. Annis, M.D., of Lakeland (left in left picture) and Augustin W. Castellanos, M.D., of Coral Gables (left in right picture). Dr. Annis, presently Vice Chairman of the American Medical Association Board of Trustees and former President of the American Heart Association, was cited as "one of Florida's premier physicians who has provided farsighted leadership for the benefit of all Florida citizens." Dr. Castellanos was honored "for achievements in the field of angiocardiography and leadership in advancing knowledge about children born with heart malformations." The awards were presented for FHA President William Madison, M.D., of Jacksonville, by Mr. Joseph B. Shearouse of Palm Beach (right in both pictures), President of the FHA Board of Directors.

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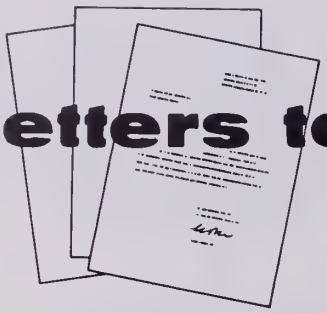
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Letters to the Editor

To the Editor: Congratulations on the comprehensive review of current pulmonary tuberculosis therapy by Goldman![1] Your readers may be interested to know that we have been using an identical treatment schema with the same chemotherapeutic agents for the past three years. Our cure rate is 95% with an average of 188 cases yearly.

All our patients have been treated as out-patients. Daily sputum smears have been negative within 48 to 72 hours of therapy. We have found no new cases due to contact with these patients during their treatment period despite the miserable living conditions in which our patients live here in the jungle. We have also confirmed the findings of the Madras study recommended in Doctor Goldmans review[2]: the improved nutrition given in a sanitarium setting contributes little or nothing towards final cure of tuberculosis while living at home among family and friends does provide a positive physical and psychological improvement not always found in sanitarium patients.

With an adequate understanding of recent advances in tuberculosis therapy plus the patience required to educate the patient about his illness, almost all cases of pulmonary tuberculosis can be be treated with a minimum of inconvenience and a maximum of positive results.

References

1. Goldman, A. L.: A New Era for Tuberculosis, J. **Florida M. A.**, 63: 278-280, 1976.
2. Tuberculosis Chemotherapy Centre Madras: A Concurrent Comparison of Home and Sanatarium Treatment of Pulmonary Tuberculosis in South India, **Bull. W. H. O.** 21:51, 1959.

Thomas Brown, M.D., Medical Director
Dispensario Medico
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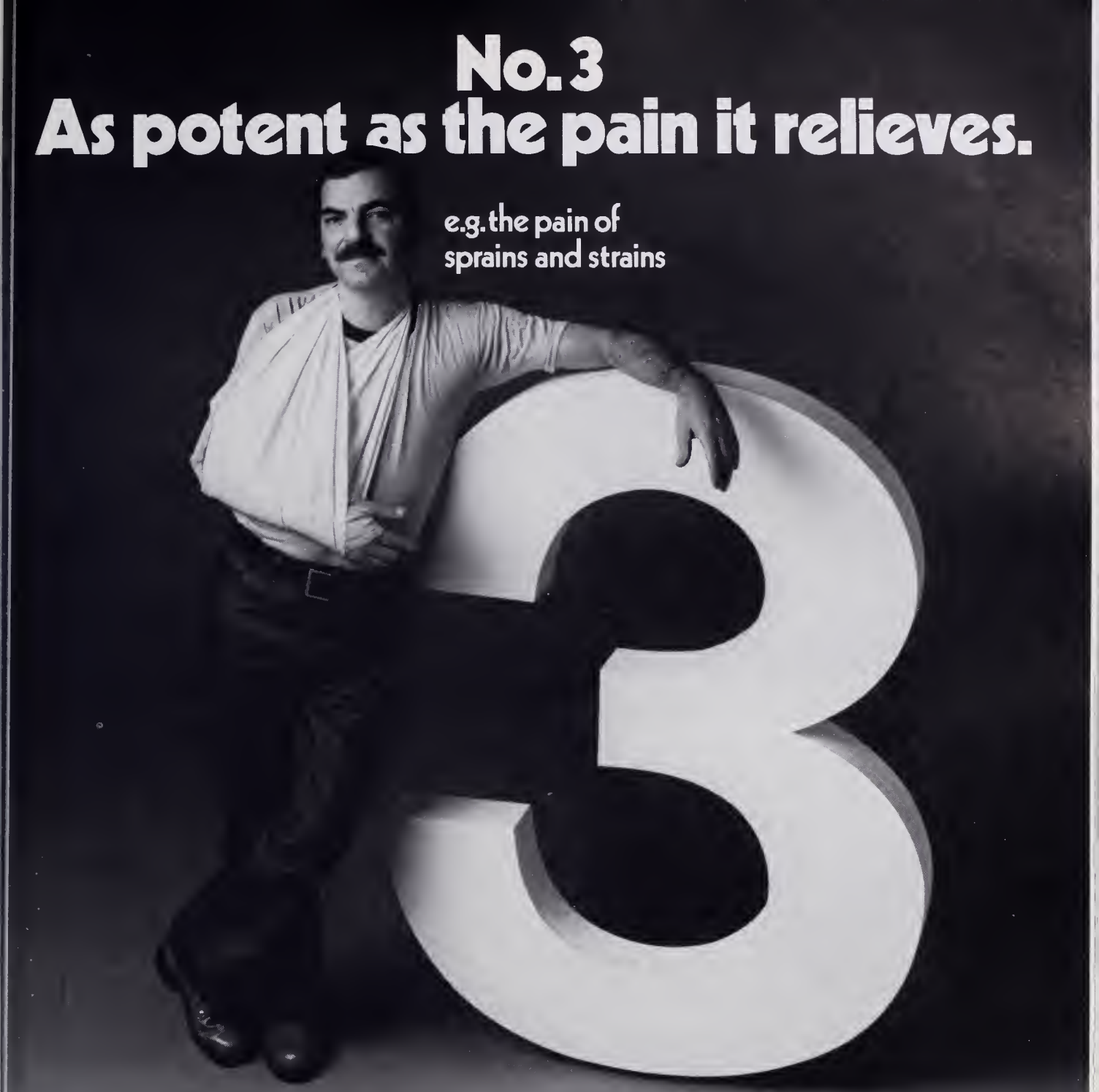
To the Editor: Outpatient therapy of tuberculosis originated in underdeveloped nations for a very practical reason—inability to institutionalize the vast number of patients. It was initially pointed out in the Madras Study that patients could be successfully treated at home and their contacts had no greater risk of developing active tuberculosis than contacts of patients who were treated entirely in sanitariums.[1] These observations have been repeated in this country and, consequently, outpatient therapy of tuberculosis has been stressed as safe and effective.[2] Further proof of the validity of this approach is found in the letter by Dr. Brown. Working in difficult conditions, Dr. Brown has achieved an excellent cure rate, probably due mainly to his patience in educating patients about their illness and their need to religiously take their medications. Although Dr. Brown states that sputum smears became negative within 48-72 hours of therapy, many of our patients have not converted their sputum smears to negative for several weeks. However, this appears to have little bearing on infectivity of the patients as has been stressed in prior studies.[1,3,4]

References

1. Goldman, A. L.: A New Era for Tuberculosis; J. Florida M.A. 63: 278-280, 1976.
2. Riley, R. L., and Moodie, A. S.: Infectivity of Patients With Pulmonary Tuberculosis in Inner City Homes, Am. Rev.. Respir. Dis. 110:810, 1974.
3. Brooks, S. M.; Lassiter, N. L., and Yuy, E. C.: A Pilot Study Concerning the Infection Risk of Sputum Positive Tuberculosis Patients on Chemotherapy, Am. Rev. Respir. Dis. 105:799, 1973.
4. Gunnels, J. J.; Bates, J. H., and Swindoll, H.: Infectivity of Sputum-Positive Tuberculosis Patients on Chemotherapy, Am. Rev. Respir. Dis. 109:323, 1974.

Allan L. Goldman, M.D.
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University of Miami School of Medicine . . . has added noted nephrologist **Neil S. Bricker, M.D.,** to its faculty. He will serve as Professor of Medicine and Vice Chairman of the Department of Medicine.

According to the School, an institute for kidney diseases will be developed under Dr. Bricker's supervision. He formerly was professor and Chairman of Medicine at Albert Einstein College of Medicine in New York City.

The Florida Department of Health and Rehabilitative Services . . . has reactivated its Emergency Medical Services Advisory Council.

The 15-member Council includes three physicians: **James Talbert, M.D.,** of Gainesville, American College of Surgeons; **Roy Baker, M.D.,** Jacksonville, Florida Medical Association; and **David Westmark, M.D.,** American College of Emergency Physicians.

The EMS Council, as well as other advisory groups to HRS had been abolished during governmental reorganization.

A University of Florida medical student . . . has received a two-year Southern Medical Association study grant.

He is **David Eugene Yocum,** son of Mr. and Mrs. Dale L. Yocum of Melbourne. Mr. Yocum will study phagocytic capabilities of acute lymphoblastic leukemia patients under the direction of Dr. Thomas Miale, Assistant Professor of Pediatrics and Director of Pediatric Hematology.

Some 3,000 physicians . . . from 31 countries will converge on Florida this fall for the 50th Anniversary Congress of the Pan American Medical Association.

More than 500 papers will be presented at 50 medical specialty sections during the meeting scheduled for Hollywood's Diplomat Hotel, Oct. 24-29. In addition, there will be 25 round-table discussions and symposia, according to Director General Joseph J. Eller, M.D., of New York.

Registration fees will include $50 for physicians and $25 for allied health professionals. No fee will be charged medical students, interns and residents.

Information is available from Pan American Medical Association, 745 Fifth Avenue, New York City 10022.

The American College of Physicians (ACP) has scheduled its Florida Regional Meeting in October.

The meeting will take place at the Marco Beach Hotel and Villas, Marco Island, October 22-24. Information may be obtained from **Charles K. Donegan, M.D.,** Governor of ACP, Florida, 501 Eleventh Street North, St. Petersburg, Fla. 33705.

Meanwhile, ACP announced that its 1976-77 schedule of postgraduate courses will include a conference on "Topics in Clinical Hematology," at Sanibel Island, January 10-13, 1977. Co-sponsors are the University of Florida and the American Society of Hematology.

Information about ACP postgraduate courses is available at the College's headquarters, 4200 Pine Street, Philadelphia, Pa. 19104.

Florida will be the host . . . for the First International Glaucoma Congress next winter.

The program, scheduled for January 31-February 1 at the Diplomat in Hollywood, is part of the 12th Annual Scientific Assembly of the American Society of Ophthalmology, which begins on January 30 and ends on February 5.

All sessions meet the criteria for 42 hours of AMA Category 1 continuing education credit, according to the Society. Information may be obtained from Dr. John Bellows, Secretary, American Society of Contemporary Ophthalmology, 6 North Michigan Avenue, Chicago, Ill. 60602.



Interested pediatricians, legislators and others gather around Gov. Reuben O'D. Askew as he signs into law the Hodes Bill (HB 3156) pertaining to regional neonatal intensive care centers. The bill, enacted by the 1976 Legislature, establishes guidelines upon which Florida will continue to build a program for the intensive medical care of prematures and neonates with special health problems. Supporters believe that full implementation of the program willl lead to a marked reduction in mortality and a significant decrease in morbidity for such as cerebral palsy, retardation and epilephan, Supervisior of Nurses, Sacred Heart Children's Hospital, Pensacola, and President of the Southern Perinatal Assosy. Left to right: Julia R. St. Petery, M.D., Staff Director, Children's Medical Services Program Office; Sister Carol Keeciation; Richard J. Boothby, M.D., Jacksonville, Pediatric Coordinator of the Florida Perinatal Program and a key figure in the development of this statewide program; State Rep. Elaine Gordon, Chairman of the House Health and Rehabilitative Services Committee; State Rep. Roger Wilson of Pinellas County, a strong supporter of the program; Gov. Askew; State Rep. Robert McKnight of Dade County, Chairman of the Health Subcommittee of the House Committee on Health and Rehabilitative Services; State Rep. Richard S. Hodes, M.D., of Tampa, FMA Treasurer and sponsor of the legislation; William J. Page Jr., Secretary of the Department of Health and Rehabilitative Services; Mr. Leo Kosky, Sen. Warren Henderson's legislative aide; and William Reed Bell, M.D., Pensacola, President of the Florida Pediatric Society.

Mid-Winter Virgin Islands Clinical Conference

The Second Mid-Winter Virgin Islands Clinical Conference will be held at St. Croix, January 13-15, 1977. The program is sponsored by the U.S. Virgin Islands Medical Society in association with the faculty of the University of Pennsylvania School of Medicine.

The program, consisting of lectures and seminars in the fields of general practice, internal medicine, general surgery, obstetrics and gynecology, and pediatrics, has been approved for 14 hours of AMA Category 1 credit.

Information may be obtained from James S. Glenn, M.D., P.O. Box 520, Christiansted, St. Croix, U.S. Virgin Islands 00820.

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en el Wolfson Auditorium

OCTUBRE 18-22, 1976

Totalmente en Español

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TOPICOS:

9:00 A.M. a 1:00 P.M., Lunes a Viernes

Asma; Obesidad, Somnolencia y Obstrucción de vías aéreas; Embolismo Pulmonar; Derrame Pleural; Corticosteroides; Shock; Quimoterapia del Cancer; Cáncer del Seno; Ecocardiografía; Cardiopatías y Radiografía de Tórax; Hipertensión Arterial; Sangramiento Digestivo; Linfomas: Abdomen Agudo.
3:00 P.M. a 5:00 P.M. Sessiones de Trabajo Simultáneas en pequeños grupos.

CUOTA DE INSCRIPCION: $150.00

(Incluye Cocktail Party y Banquete de Clausura)

Este Seminario ofrece 22 horas de crédito en la categoría I para el "Physician's Recognition Award" de la AMA, 22 horas Mandatorias para la FMA y 22 horas "Prescribed" para la AAFP.

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MEETINGS

Approved by FMA Committee on Continuing Medical Education

SEPTEMBER

Pediatric Pulmonary Disease, September 3-4, Sacred Heart Children's Hospital Auditorium, Pensacola. For information: Reed Bell, M.D., 5151 North 9th Avenue, Pensacola 32504.

Seminar in Neurological Sciences, Sept. 10-11, Sarasota Hyatt House, Sarasota. For information: William M. Haycock, M.D., 2550 Park St., Jacksonville 32204

Clinical Electrophysiology, Sept. 15-17, Wolfson Auditorium, Mount Sinai Hospital, Miami Beach. For information: CME Coordinator, Mount Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

Twenty Fourth Annual Diabetes Seminar, Sept. 17-19, Jacksonville. For information: Robert Miller, M.D., 1545 San Marco Blvd., Jacksonville 32207.

When Should I Get Neurologic Consultation? September 24-25, Galatea Inn, Pensacola Beach. For information: R. Douglas Collins, M.D., 1000 West Moreno Street, Pensacola 32501.

Trauma Systems and Management, A National Symposium, September 24-26, Innisbrook Resort, Tarpon Springs. For information: Lamar Crevasse, M.D., Box J-233, JHM Health Center, Gainesville 32610.

Consultations in Hypertension, September 29, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Hospital Infection Control Practices—1976, Sept. 29-30, South Building Auditorium, Cedars of Lebanon Health Care Center, Miami. For information: N. Joel Ehrenkranz, M.D., 1400 Northwest 12th Ave., Miami 33136.

OCTOBER

First Annual Reunion, University of Miami, Department of Family Medicine, Oct. 3-5, Americana Hotel, Miami Beach*

▸ **American Group Practice Association,** Oct. 5-8, Americana Hotel. For information: AGPA, 20 South Quaker Lane, Alexandria, Va. 22314.

Obstetric/Gynecology Review Course, Oct. 2-10, Miami*

Topics in Family Medicine 1976, Oct. 6-10, University of Miami School of Medicine, Department of Family Medicine*

Review Course on **"Fundamental and Clinical Aspects of Internal Medicine,** Oct. 10-23, Key Biscayne Hotel, Miami*

Fourth Family Practice Review, Oct. 11-16, Gainesville Hilton, Gainesville**

17th Workshop In Electrocardiography for Cardiac Nurses & Interested Physicians, Oct. 14-18, Tides Hotel, Redington Beach, St. Petersburg. For Information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

25th Basic Colposcopy Course, Oct. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Charles B. Slack, Inc., 6900 Grove Rd., Thorofare, N.J. 08086

Second Pan American Seminar, October 18-22, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel, Key Biscayne.*

FSIM/ACP Joint Fall Meeting 1976, Oct. 22-24, Marco Beach Hotel and Villas, Marco Island. For information: Florida Society of Internal Medicine, 515 Lomax St., Jacksonville 32204

NOVEMBER

Program for Foreign Medical Graduates, Nov. 1 & Jan. 22, Miami*

Hepatobiliary Disease in Clinical Practice, Nov. 11-13, Miami*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 11-13, Miami*

Pacemakers Updated, Nov. 13-14, Deauville Hotel, Miami Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

Initial Management of the Pediatric Emergency, Nov. 17-21, Caesars Palace, Las Vegas, Nevada. For information: J. Clifford Findeiss, M.D., 3900 Northwest 79th Avenue, Suite 469, Miami 33166.

Legal and Medical Aspects of Human Sexuality, Nov. 18-20, Miami*

Third Workshop in the Use of Staplers in Surgery, Nov. 19-20, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Anesthesia Management for the Surgical Patient, Nov. 29-Dec. 12, Miami*

Emergencies in Internal Medicine, Nov. 30-Dec. 4, Miami*

DECEMBER

Emergencies in Internal Medicine: Diagnosis and Management, Dec. 1-4, Americana Hotel, Miami Beach*

Symposium on Pathology, Dec. 7, Watson Clinic, Lakeland. For information: Eugene T. Davidson, M.D., Watson Clinic, Lakeland 33802

▸ **AMA Scientific Assembly,** Dec. 10-13, Miami. For information: AMA, Dept. of Continuing Education, 535 N. Dearborn St., Chicago 60610

1977

JANUARY

Pediatric Nephrology Seminar IV, Jan. 3-6, Miami*

Neuro-Ophthalmology Seminar, Jan. 3-7, Miami*

Midwinter Cruise—Symposium on Intensive Care, Jan. 6-15, Miami*

Miami Winter Symposia—Biochemistry, Jan. 10-14, Miami*

Human Disease Related to Food and Chemical Sensitivity, Jan. 12-15, Miami*

11th Annual Postgraduate Seminar in Surgery, Jan. 12-15, Miami*

Hematology and Oncology 1977, Jan. 13-16, Miami*

Nephrology 1977, Jan. 14-15, Miami*

Pulmonary Disease 1977, Jan. 14-15, Miami*

Arthritis 1977, Jan. 14-16, Miami*

Gastroenterology and Hepatology 1977, Jan. 14-16, Miami*

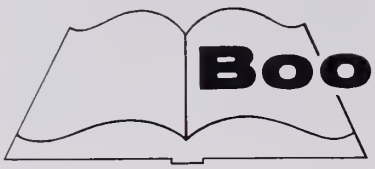
Internal Medicine 1977, Jan. 15-21, Miami*

Second Review and Practical Advances in Pathology, Jan. 16-21, Miami*

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.



Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

The End Of Medicine by Rick J. Carlson. 290 pages. Price $12.95. New York, John Wiley and Sons, 1975.

My prejudice was, before I read the book, that I wouldn't like it because it would be "anti-doctor." Now I'm not sure. I can agree with part. With some parts, I disagree. In the points of agreement, the author and I arrive at the same place, conceptually, though arriving there through totally divergent pathways.

Points of agreement: The impact of medical care on health is less than the general public assumes. People must relearn how to take care of themselves and one another. Strikingly, Carlson theorizes, "If a comprehensive program of national health insurance is promulgated in the next few years, as is almost certain, the structure, prerogatives and style of practice of the existing medical care system will be frozen for decades." Maybe even fossilized, Mr. Carlson.

Points of disagreement: Mr. Carlson is for pleuralism in medicine. So am I; however, he loses me completely when the pleuralism includes quackery such as "psychic surgery." My trust level for Mr. Carlson's work was shattered when I discovered multiple, gross typographical errors, especially in the names of drugs and diseases. If the proofreading was lax, what about the scholarship?

Mr. Carlson states that if a national health insurance bill is passed by the United States, "As a nation we will have then decided to further feed an already bloated system and in so doing divert monies that could otherwise be spent to ameliorate social and environmental conditions that have a demonstrably greater impact on health, such as poor housing and malnutrition. And, most tragically, we will deepen the dependency of consumers on services and providers." Mr. Carlson, part of this sounds like the American Society of Internal Medicine testimony to the Senate Committee on Health. Society in general, and not physicians alone, must decide what the priorities are. Interestingly enough, forces outside of organized medicine are beating the drum to make the health care system monolithic and overly governmentally regulated.

Lest we all take Mr. Carlson's book completely to heart and divest ourselves of our medical practices, it may be well to remember his phrase," . . . real change. in medicine and health as in anything else, cannot be accomplished without a radical transformation of humanity." Mr. Carlson gives no evidence, in his book, that this is about to happen. I haven't seen any evidence of this myself lately.

F.N.V.

Physician's Handbook by Marcus A. Krupp, et. al. 18th Ed. 754 Pages. Price $8.00. Lange Medical Publications, Los Altos, California, 1976.

As usual, this pocket sized book is packed with information. Designed with the house officer in mind, it can be carried easily in a coat pocket or physician's bag.

The section on medical genetics is brief but informative. This small, ready-reference adequately fulfills its purpose.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Food For People, Second Revised Edition, by Sarah R. Riedman. 228 Pages. Illustrated by Robert McGlynn. Introduction by Lord John Boyd Orr. Price $6.95. New York, Abelard-Schuman, 1976.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 Pages. Price $35.00. 354 Illustrations. St. Louis, The C. V. Mosby Company, 1975.

Head Nurse by Barbara Villet. 201 Pages. Price $7.95. Garden City, New York, Doubleday & Company, Inc., 1975.

The Hand: Principles and Techniques of Simple Splintmaking in Rehabilitation by Nathalie R. Barr M.B.E., F.B.A.-O.T. 152 Pages. Price $11.95 (cloth), $5.95 (paper). Reading, Mass., Butterworths, 1975.

Principles of Clinical Electrocardiography, 9th Edition by Mervin J. Goldman, M.D. 412 Pages. Illustrated. Price $9.50. Los Altos, California, Lange Medical Publications, 1976.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

The New Way to Live With Diabetes by Brian Boylan and Charles Weller, M.D. 140 Pages. Price $2.50 (paperback). Doubleday & Company, Inc., New York, 1976.

The Woman Alcoholic by Vera Lindbeck. 28 Pages. Price 35¢. New York, Public Affairs Pamphlets, 1975.

Focus on Care of the Elderly by Donald F. Phillips et al. 114 Pages. Price $4.75. Contemporary Publishing, Inc. Wakefield, Massachusetts, 1975.

Preparation for Parenthood Through Group Discussion by Aline B. Auerbach. 57 pages. Available on request from Educational Services, Patient Care Division, Johnson & Johnson, New Brunswick, N. J. 08903.

This book by a parent group consultant is subtitled, "A Guide For Nurse-Leader of Expectant-Parent Classes". This guide includes chapters on organization of expectant parent discussion groups, basic requirements for leadership, as well as techniques of group discussion and suggested curriculum. It includes a bibliography for suggested reading.

Review of Medical Microbiology, 12th Edition, by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. 542 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price $15.00. Los Altos, California, Lange Medical Publications, 1976.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus,** volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

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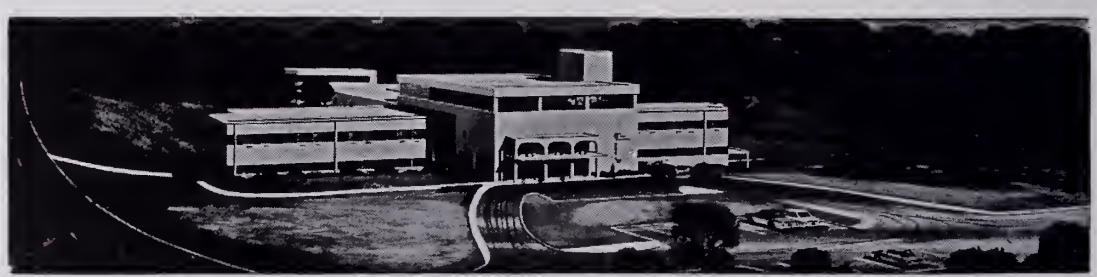
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N E FLORIDA—SMALL CHILDREN'S HOSPITAL expanding Department of Anesthesiology. Immediate opening for staff anesthesiologist with pediatric experience, board certified or board eligible. Salary and benefits commensurate with experience. Contact: Chief of Anesthesiology, Hope Haven Children's Hospital, 5720 Atlantic Boulevard, Jacksonville, Florida 32207.

MISCELLANEOUS

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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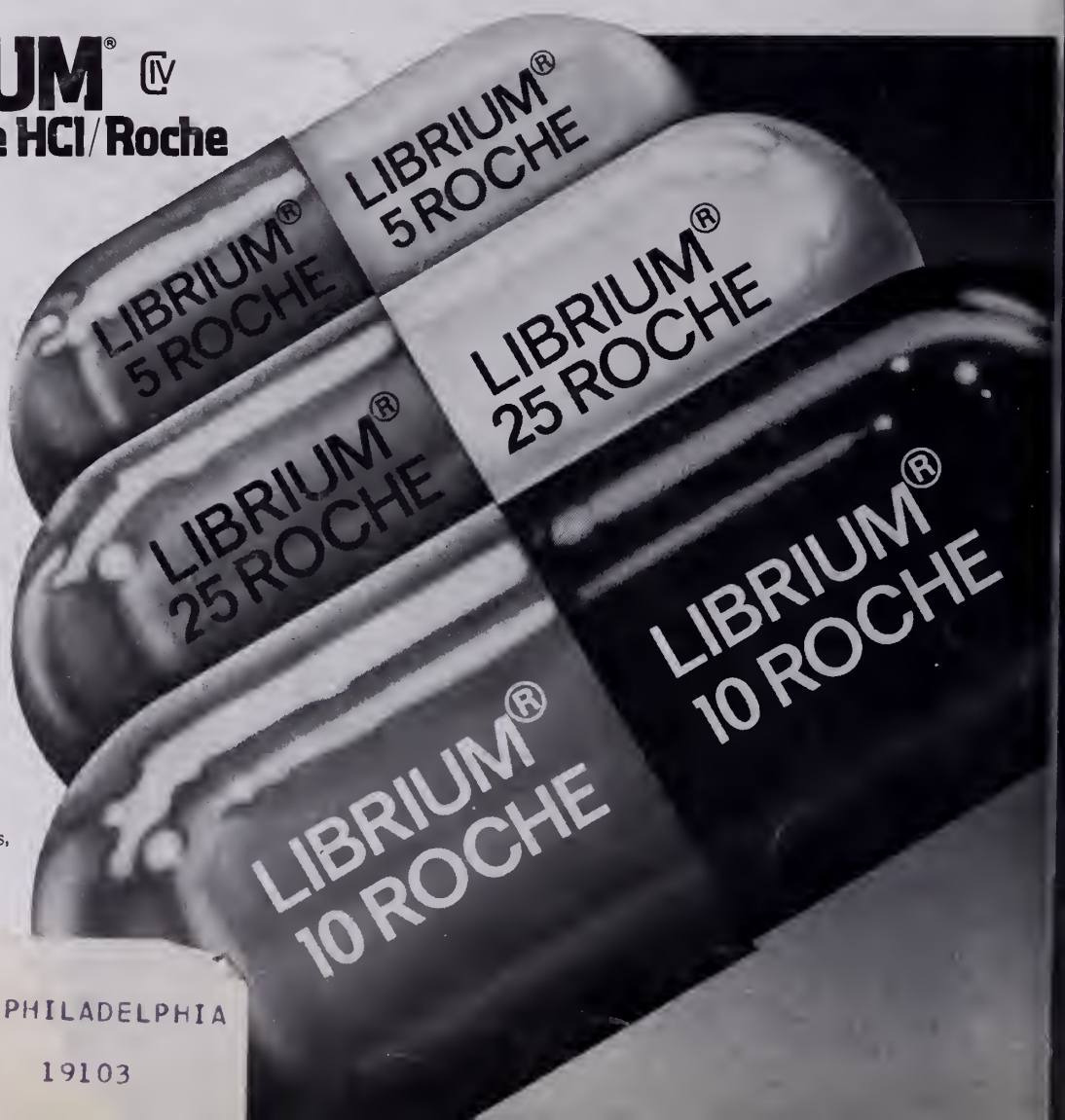
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC

OCTOBER 1976 • VOL 63 • NO 10

SPECIAL ISSUE
UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE

Bernard J. Fogel, M.D.
Guest Editor

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Special Issue
University of Miami

Resolution 755
An Historical Perspective of the University of Miami School of Medicine
Henry King Stanford, Ph.D., LL.D., D.C.L., D.Litt. 756
A Medical Center and the Achievements of a Young Medical School
Emanuel M. Papper, M.D. and Bernard J. Fogel, M.D. 758
Medical Students 764
The Research Program of the University of Miami School of Medicine
William J. Harrington, M.D. and Gerald S. Atchison 767
The University of Miami School of Medicine's Alumni During the School's First Twenty Years
Marilyn Mendelson, Ph.D., Bernard J. Fogel, M.D., John K. Robinson, M.D. and Emanuel M. Papper, M.D. 771

Special Articles

Commencement Address—1976
Emanuel M. Papper, M.D. 781
Hospital Contingency Plan for "Swine-Flu" Epidemic
Pat Robertson, R.N. and William P. Douglass, M.D. 784

Sections

President's Page
JACK A. MACRIS, M.D. ... 745
Books Received ... 793
Book Reviews ... 792
Dean's Page
The University of Miami—Jackson Memorial Medical Center
EMANUEL M. PAPPER, M.D. ... 748
Deaths ... 800
From the Editor's Desk ... 752
Letters to the Editor ... 805
Medical News Around the State ... 796
Organization
Report on National Rural Health Conference
R. EDWARD DODGE, M.D. ... 787
Volusia County Physician Ministers to Speedway Injured ... 788
Others Are Saying
Medicaid Should Work Better
COLLINS CONNER ... 806
The Art of Delivering Bad News
HOWARD P. HOGSHEAD, M.D. ... 807

Information

Classified Advertising ... 811
FMA Officers and Council Chairmen ... 814
Information for Authors ... 793
Index to Advertisers ... 814
Meetings ... 808

OCTOBER COVER—An aerial view of the University of Miami—Jackson Memorial Medical Center complex highlighting this special issue dedicated to the University of Miami School of Medicine and its accomplishments. We are most grateful to Dr. Bernard J. Fogel for the tremendous effort and amount of time he has devoted to bringing this issue to its completion.



President's Page

P-R

We have embarked on a public relations program, and being neophytes in such an endeavor we have asked a group of professionals for help. As we initiate the suggested plan of action, let us pause a moment to look at the total picture.

The polls continue to find us at the top of the list of the most respected of professional and business groups. We enjoy our work, earn a good income for our labors, and have a high job satisfaction percentage. This picture exists in spite of a prolonged wave of criticism, and a concerted attack upon the image of the profession. It might seem, therefore, a waste of time, energy and money to undertake such a program under such rosy circumstances. However, each of us knows inroads have been made by our critics, and it is this fact that warrants our scrutiny and our energy if we are to remain at the top.

Our critics do not attack us individually, but portray us as a group of uncaring, money-hungry, high-handed individuals, lacking compassion in the handling of our patients. The public has accepted this portrayal to some extent, each of them quietly thinking to himself that he or she was clever enough, and fortunate enough, to have selected each of us as their doctor to minister to each of them.

Our critics further attack the profession saying it is an inefficient one, that health care delivery here is a "cottage industry," and it fails to meet the need of a growing demand for services. In the same breath, doctors are bitterly criticized for refusing to make house calls, the most inefficient (but most personal) form of health care delivery devised. Production line methods, using HMO-type group practices to "streamline productivity," and the use of Physician Assistants to spread the doctor thinner, are touted as remedies. While espousing these plans which further depersonalize the doctor-patient relationship, the next criticism is that we don't spend enough time with our patients, don't get to know them well enough, and no longer act as their family advisors.

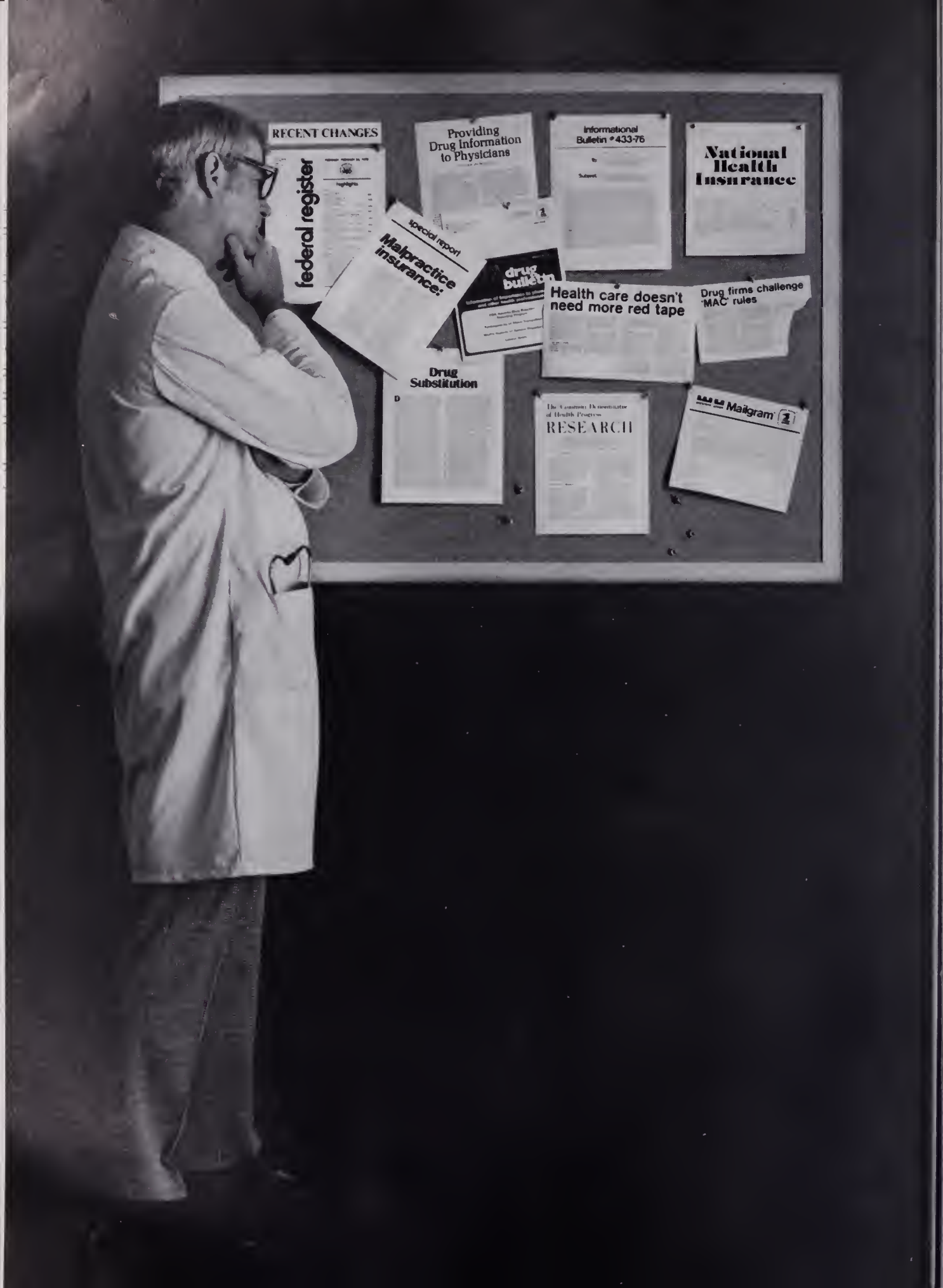
The fact that the criticisms are contradictory and inaccurate is of no concern to our critics. Each barb does its little bit of damage. Thus, we have undertaken a positive program to bring our side of the story to the fore. This will be done in the form of a statewide media-oriented program. This can in no way replace the far more important and effective impression left upon our patients as we care for them. Each day in our offices and in the hospitals, if we are mindful of their needs as individuals, both physical and emotional, we can accomplish what no amount of Madison Avenue P-R endeavor can hope to.

More hospitals are becoming aware of the value of personal attention, and are instituting programs to dispel the impersonal attitudes in hospitals. Details such as greeting the patient as he or she arrives on the hospital floor, a concerted effort to improve the food service, and more attention to the personal comfort as well as the medical needs of the patient, are good starting points. These programs reflect a more personal attitude in patient care, and can be accomplished without additional personnel. These programs should be encouraged and instigated by us in our hospitals throughout the state.

If you will permit a momentary aside, the house call remains a fascinating phenomenon. As mentioned, it fell by the wayside of "progress" because of its inefficiency, both in time and in effective treatment of illness. Yet, it is sorely missed, and its abandonment resented. It has become the symbol of compassionate care to the public, and perhaps no greater bit of image-polishing can be achieved than by its judicious use.

"You can't make a silk purse out of a sow's ear." Neither do we have to, nor intend to, for we are not starting with a sow's ear. We are starting with the noblest profession of all, and by our actions, and with some help, we would like to keep it the noblest in the minds and hearts of our patients, the public.

Jack A. Wallis, M.D.


RECENT CHANGES
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Dean's Page

The University of Miami Jackson Memorial Medical Center

E. M. Papper, M.D.

The cover of the October issue of the Journal of the Florida Medical Association depicts a recent aerial view of the University of Miami-Jackson Memorial Medical Center. We regard this photograph of our growing medical complex with deep satisfaction. The "first accredited medical school in Florida" has come a long way since its beginning in 1952. Many additional plans for further enlargement are on the drawing board. This rapid expansion can be attributed in part to the growth of the Medical School's primary teaching facility, the Jackson Memorial Hospital, which is the responsibility of the Public Health Trust of Dade County. Both institutions have kept pace in their development because of their natural interdependency and mutual goals of excellence.

During the past several months, the University of Miami-Jackson Memorial Medical Center dedicated two new buildings, each incorporating hospital design and engineering concepts which emphasize the principle that accessibility between medical personnel and patients is essential to excellent health care delivery.

On May 16th, 1976, the Public Health Trust dedicated the new fourteen story West Wing at Jackson Memorial Hospital, the first phase of our overall plan to modernize our already large medical training and health care center. It represents the result of dedicated work by the Public Health Trust Board members, the Dade County Commissioners, Jackson Memorial Hospital, and the School of Medicine. Mr. William D. Singer, Public Health Trust Chairman, deserves substantial credit for his leadership and determination in bringing Phase I to successful completion.

United States Representative Paul G. Rogers, of West Palm Beach, known as "Mr. Health" in the House of Representatives, noted at the dedication that "the new addition is more than a County resource. It is a resource for the entire State of Florida. In fact, records establish that it is the regional resource for many neighboring states, the nearby islands and countries to the south of us. . . . The work done here in conjunction with the University of Miami School of Medicine also establishes it as a national resource."

The completion of the new clinical tower has signaled the onset of the planning to launch the next phase of renovation and modernization. Included in the Medical Center's plans are construction of a new Primary Care-Ambulatory Health Center, a new Rehabilitative Center for all of Florida, additional clinical laboratories, a maternal-child clinical tower, and a modern emergency room. All of these facilities were approved on November 7, 1972, by the Dade County citizens who voted for the $88.6 million Decade of Progress Bond Issue.

The opening of the new clinical tower was complemented three weeks later, on June 5, 1976, by the dedication of the Anne Bates Leach Eye Hospital. This superb ophthalmologic institute is the culmination of a fourteen year dream of the staff of the Bascom Palmer Eye Institute. It will permit these dedicated faculty members and staff to have all of their clinical, diagnostic, surgical and administrative facilities assembled under one roof. The new eye hospital, one of the most beautiful and innovative health facilities in the United States, represents a major commitment on the part of the University of Miami and the faculty of the Department of Ophthalmology to prevent and eventually eradicate the devastating effects of eye disease. Dr. Edward W. D. Norton, Professor and Chairman of the Department, was the driving factor for making this new facility become a reality. We believe that the eye hospital enhances our ability to function as a national and international resource.

Perhaps in 1980 the Editors of the Journal of the Florida Medical Association will give us the opportunity to illustrate the results with another aerial view of the next phase of our planning. We hope by then we will have completed our goal to construct a model, efficient health care facility geared to high quality patient care, education and research.

Dr. Papper, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152.

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

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"Approximately 95% of the [U.S.] children of ages 1-5 years had iron intakes below the standard"

U.S. Public Health Service (1974)

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Were they really dealing with a true sample of the entire U.S. population?

Those conclusions were based on a sample of 10,126 people—a probability sample established by the U.S. Bureau of Census to reflect the country's total population, regardless of race or income.

Among those 95% with substandard iron intake, how low was their intake actually?

For whites and blacks, for both sexes, for both income levels, the mean intake of iron (as a percent of the standard) for the 1-5 year age group ranged from 60 to 69%. Typically, then, 95 children out of 100 have iron intakes that are only ⅔ of the standard.

Whose iron intake standard were they using?

The standard set by the Food and Nutrition Board of the National Academy of Sciences for this group.

Implication of all this?

That iron deficiency among preschoolers is anything but rare and signs like mental apathy, lethargy, irritability, behavior problems, may be telegraphing iron deficiency.

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Is this cited study generally available?

Yes, from the Office of Information, National Center for Health Statistics, 5600 Fishers Lane, Rockville, MD., 20852. Request "First Health and Nutrition Examination Survey", 1974, DHEW Pub. No. (HRA) 74-1219-1.

*B. Blackwell: The Drug Defaulter. *Clinical Pharmacology and Therapeutics* 13:841 (1972).

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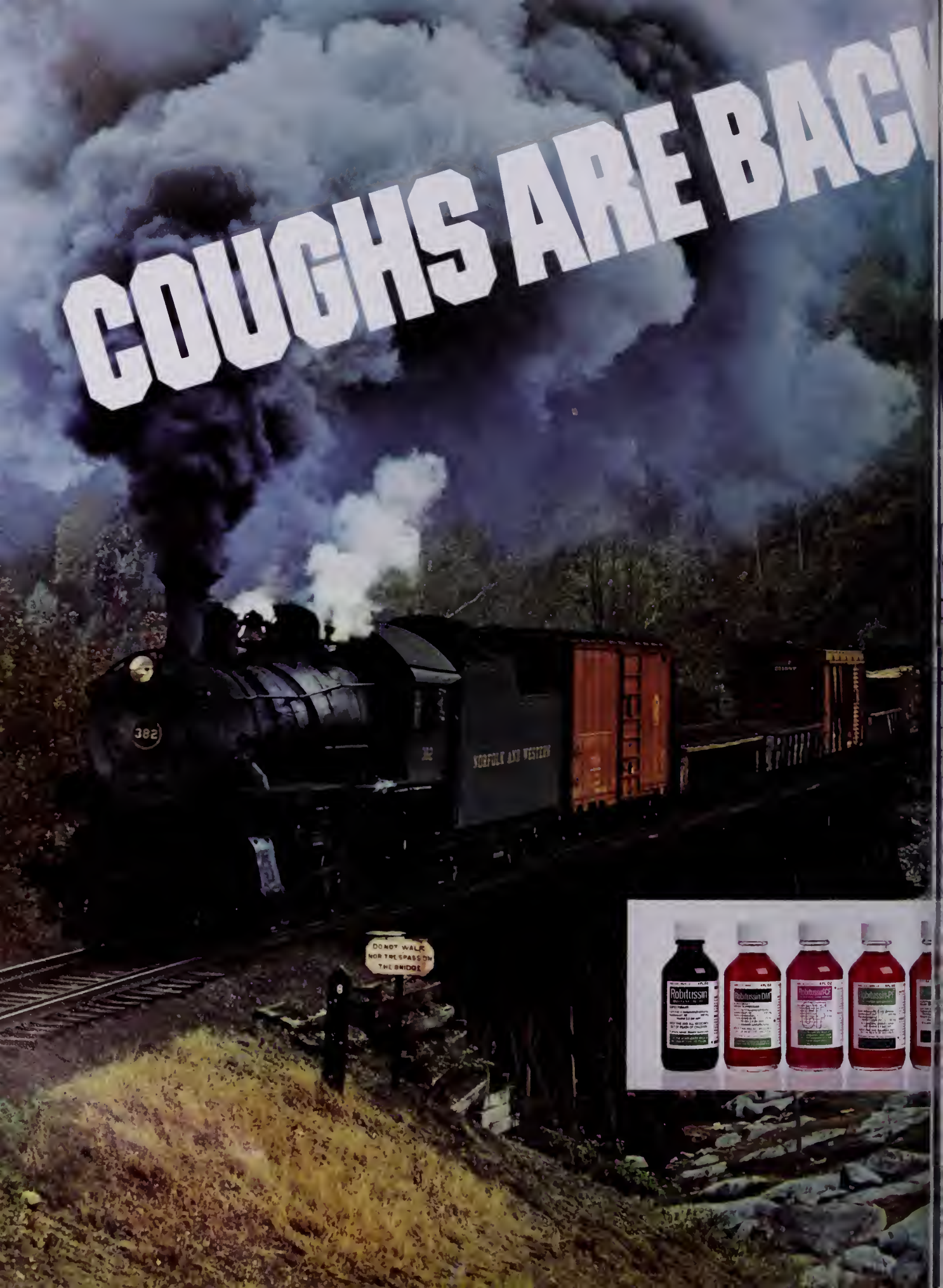
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UR PHOTO: Norfolk & Western Branch Train o. 202 west bound near Alvarado, Va. (Oct., 1956). his line reaches the highest point of any railroad ast of the Rockies (elevation 3,577 ft.) with a inimum grade of 3%. It crosses 108 bridges, ome 700 ft. long! Photo by O. Winston Link.

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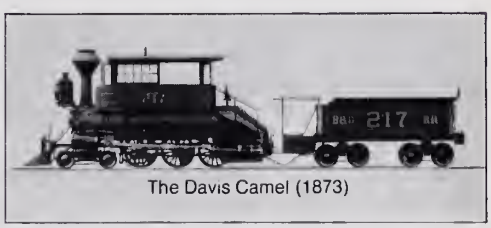
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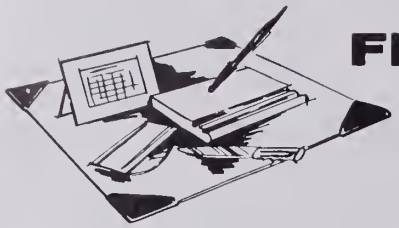
For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



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FROM THE EDITOR'S DESK

Thirty-two students have been accepted conditionally for the first entering class at the nation's new military medical school.

The charter class at the Uniformed Services University of the Health Sciences was selected from among 1,700 applicants. The aspiring military physicians will begin a four-week military orientation period on October 12, then begin medical school classes at the Walter Reed Army Medical Center in Washington.

It's expected the school will move into its permanent facilities at the National Naval Medical Center in Bethesda, Md., by the time next year's class enters.

The Liaison Committee on Medical Education has granted provisional academic accreditation to the school's program.

* * * *

AMA had 144,107 dues-paying members as of July 9, just a hair short of the 144,500 on which the 1976 budget is based. "We are well on our way to the 150,000 mark," said one AMA official. Florida and five other states showed an increase in their AMA memberships over their July 9, 1975 figures. Meanwhile, the AMA House of Delegates commended the Board of Trustees for bringing about "dramatic improvement" in AMA's shaky financial situation.

* * * *

Francis C. Coleman, M.D., Tampa, represented the AMA in testimony before the Council on Wage and Price Stability. He warned that health care "quality and access must not be sacrificed in the name of cost reduction or overly stringent cost control." He said AMA supports voluntary health planning to avoid unnecessary duplication of expensive facilities, has always supported voluntary peer review and appropriate utilization review, and has urged physicians to be cost-conscious in their decisions.

Three state medical associations, including FMA, have been applauded by AMA for supporting physicians who strike back at plaintiffs and lawyers who pursue non-meritorious professional liability suits. The California and Illinois medical associations also were recognized.

* * * *

The Consumer Price Index for May showed a decline in the rate of increase for physicians' fees for the second month in a row. Fees increased only .6%, compared with .7% in April. The all items and all services index, meanwhile, rose from .4% to .6%, and .3% to .4%, respectively.

* * * *

The State of Missouri has filed suit in Washington challenging the National Health Planning and Resources Development Act. The suit charges there is no statutory basis for the law's regulations limiting to one-third the number of public elected officials who can serve on the governing body of a health systems agency. Meanwhile, AMA seeks to join as a co-plaintiff in a North Carolina suit also challenging the law.

* * * *

Primary care specialties are enjoying a surge in popularity among new medical graduates. The AMA Council on Medical Education reports that about 60% of this year's crop of new M.D.'s chose primary care in this year's matching program. Since 1970, 270 residency programs in family medicine have been created.

* * * *

Americans lives are getting longer. Life expectancy rose from 71.9 years in 1974 to 72.4 last year.

The Editor

Roerig presents a guide through the labyrinth of vertigo



Vertigo is a potentially complex condition often encountered in office practice. Over 3.5 million patient visits last year were traceable to conditions of the inner ear, with vertigo or dizziness as prominent symptoms.

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Resolution

Senate Concurrent Resolution No. 1459

A concurrent resolution proclaiming October 15,

1976 as University of Miami Day in Florida.

WHEREAS, the private, independent, international, and nonprofit University of Miami, chartered by the State of Florida, is observing its Golden Anniversary in 1976, and

WHEREAS, the University of Miami survived the historic hurricane of September, 1926, and enrolled its first students in Coral Gables on October 15, 1926, and

WHEREAS, the University of Miami has grown in fifty years into one of the major private institutions of higher learning and research in the nation and has awarded more than 61,000 accredited degrees to its graduates, more than half of whom have been native Floridians, and

WHEREAS, the University of Miami has brought great cultural, educational, and professional advancement to the people of Florida through its multiuniversity programs in the arts and sciences, law, engineering, oceanography, business, music, nursing, education, medicine, and continuing studies, saving the citizens of Florida millions of dollars through private funding, and

WHEREAS, the Legislature deems the University of Miami on its Golden Anniversary to be worthy of the recognition of the citizens of our state and wishes to designate a University of Miami Day in Florida, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida, the House of Representatives Concurring:

That October 15, 1976, is hereby proclaimed as University of Miami Day in Florida, and the citizens of Florida are urged to reflect on the contributions and role of this great private University in our State and Nation.

BE IT FURTHER RESOLVED that a copy of this resolution, duly attested, be presented to the University of Miami and to Senator R. Bunn Gautier, Trustee of the University of Miami, as a tangible token of the Legislature's appreciation and recognition of the accomplishments of the University.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC
OCTOBER 1976 • VOL 63 • NO 10

SPECIAL ISSUE
UNIVERSITY OF MIAMI
SCHOOL OF MEDICINE

An Historical Perspective of the University of Miami School of Medicine

Henry King Stanford, Ph.D., LL.D., D.C.L., D.LITT.

In recognition of the 50th Anniversary of the University of Miami and the 20th class to receive the Doctor of Medicine degree from the School of Medicine, Gerold L. Schiebler, M.D., Editor of the Journal of the Florida Medical Association, has graciously assigned this special issue to the University of Miami School of Medicine. He has invited members of the faculty and administration to report some unique aspects of this School which the members of the Florida Medical Association should find of interest.

The Medical School was ten years old when I assumed the Presidency of the University of Miami in July 1962. By that time, the external and internal frictions which had hampered the School's early progress — and no one who knows the history denies this tumultuous beginning — had been overcome to a large extent and the momentum had been generated to carry it to its present outstanding place in medical education. When I was briefed on the history of this exciting facet of the University of Miami, I learned that the need for a source of medical education in Florida was recognized in 1926 by Dr. Bowman F. Ashe, Founder and First President of the University of Miami, who envisioned medical and dental adjuncts to the institution. He knew of the three-year period in the late 1880s when the Tallahassee College of Medicine and Surgery struggled but failed to produce any graduates. From that time Floridians wishing to become physicians had to go out of state.

However, it was not until the late 1940s that a ground swell appeared in the state legislature to rectify the lack of medical education in Florida. R. Bunn Gautier, Senator from Dade County, led the passage of a bill in the legislature which committed the state to subsidize the "first accredited and approved medical school established in the State of Florida" with the sum of $3,000 to be paid to the school for each Florida student enrolled. This became law in July 1951 and the legislature appropriated $225,000 to cover the period of July 1, 1951 through June 30, 1953.

With this incentive, a group of prominent Dade County citizens, made up of physicians, civic and political leaders, came forward strongly advocating that the medical school be situated in South Florida and be under the auspices of the University of Miami, then, as now, "a private, independent, international university."

Anyone knowing the factionalism that existed at that time between North and South Florida would

Dr. Stanford is President of the University of Miami.

have expected a tug of war as to the site of the school — inevitably it arose. Although the statute was nonspecific on the subject, there were those who thought a state-subsidized school should be state-operated and not part of a private institution.

It took decisions all the way to the State Supreme Court to clear away the legal roadblocks that were thrown up by opponents.

The founders of the school also had to overcome the time element imposed by the period covered by the state's appropriation. To meet the deadline, they had less than a year to find quarters for classrooms, laboratories and administrative offices, to recruit a basic science faculty, enlist students (who could meet both the Florida residency and the county quota requirements) and to establish a curriculum.

I am told there were many skeptics who felt the school would never make it. They were wrong. The medical school held on and grew far beyond expectations.

In September 1952 four faculty members and 28 students started holding classes in a pseudo-Spanish style building which had been built in 1926 to serve as a dormitory for the domestic staff of the Biltmore, a resort hotel in Coral Gables. Two years later the students and some of the faculty began making the 16-mile round trip to county-owned Jackson Memorial Hospital, which served as the major clinical teaching facility. The commuting was to continue for about 17 years, until 1969, when the Rosenstiel Medical Sciences Building was completed in the Medical Center.

Many Dade County physicians served on the School's clinical faculty, particularly during the early years, providing a welcome and excellent source of talent. The voluntary clinical faculty still numbers nearly 1,000 and make a substantial contribution to the training of our state's and nation's future physicians. Equally important, the School has established strong relations with the Dade County Medical Association as well as with the Florida Medical Association.

The early sixties were characterized by intramural strife which disrupted the full-time faculty and resulted in a critical report from the American Association of University Professors. Following a reshuffling of personnel, these problems were successfully overcome.

Jackson Memorial Hospital remains the principal teaching hospital and is now operated by the Public Health Trust of Dade County. In the 22 years since affiliation between the School and Jackson a dozen major buildings have sprung up on the 65-acre site making the medical complex the fifth largest medical center in the United States. Nearing completion are the 14-story West Wing, which will replace some of Jackson's antiquated facilities, and the seven-story Anne Bates Leach Eye Hospital, which will house the School's internationally known Department of Ophthalmology.

Even more construction is in the works. The Public Health Trust recently approved Phase Two of the overall plan for completely modernizing the hospital. Two patient care towers have been designed to provide space to replace 300 beds, new facilities for ambulatory care, labor and delivery rooms, laboratories, a new emergency room, and an expansion of the rehabilitation center. Completion is projected prior to 1980.

The foregoing is only a brief overview of the University of Miami School of Medicine, where it has been and where it is going. Elsewhere in this issue, E. M. Papper, M.D., Vice President for Medical Affairs and Dean of the School, and Bernard J. Fogel, M.D., Assistant Vice President for Medical Affairs and Associate Dean for Medical Education, will expand on the School's evolution and its accomplishments.

▸ Dr. Stanford, University of Miami, Coral Gables 33124.

A Medical Center and the Achievements of a Young Medical School

Emanuel M. Papper, M.D. and Bernard J. Fogel, M.D.

Medical Center

After the Florida Legislature appropriated funds for establishment of the first accredited medical school in the state, University of Miami officials arranged with the Veterans Administration, then in Coral Gables, to lease an unused structure for the School of Medicine. Hasty remodeling turned what was once the servants' quarters of the old Biltmore Hotel into classrooms and laboratories for the teaching of the basic sciences (Fig. 1).

The first departments initiated in the new school were those required for the freshman curriculum and the training of the School's first 26 students. The Departments included Anatomy, Biochemistry, Physiology, and Psychiatry. A year later, Microbiology, Pathology and Pharmacology were added. These were followed by Medicine, Obstetrics and Gynecology, Pediatrics and Surgery. In the ensuing years the School has established 23 departments; the latest two being Family Medicine and Oncology in 1974.

In 1952 a contract was signed between Dade County and the University of Miami whereby Jackson Memorial Hospital would become the primary teaching hospital of the School of Medicine. Dade County also agreed to construct and equip a medical research building and an outpatient building immediately adjacent to the Hospital. The outpatient building was built by the County at a cost of approximately $1 million and was opened in June 1955. Following passage of the Health Research Facilities Act, a million dollars of county funds were matched with an equal amount of federal funds making possible the construction of the School's Medical Research Building. This eight-story building opened in 1959 and provided desperately required space for the School's burgeoning research program. Meanwhile other medically oriented facilities were being developed in the same area, and a major medical center began to emerge as the University entered the 60s.

In 1962 the Bascom Palmer Eye Institute was built to house the Department of Ophthalmology and its clinic. It is now one of the finest institutions of its kind in the United States. Next month, the new Anne Bates Leach Eye Hospital will open and further expand the activities of this internationally recognized department (Fig. 2).

In 1964, by action of the Board of Trustees, the National Children's Cardiac Hospital (now called the University of Miami Hospital and Clinics/NCCH) became an integral part of the University of Miami (Fig. 3). This Institution is at present the major diagnostic center for the private practice of the School of Medicine's faculty.

Few medical schools in modern times have had to contend with such inadequate facilities for so long a period as the University of Miami School of Medicine. The earliest records reveal that the servants' quarters in the Biltmore Hotel were expected to house the basic science departments no more than two years. Seventeen years later (1969), the building was used to train medical students. Small cottages once condemned by Jackson Memorial Hospital served as offices for many of the clinical faculty. In some instances, six or more faculty members shared rooms no larger than kitchenettes.

Almost immediately the Medical Research Building became inadequate to meet the research space requirements of the School. Additional research laboratories were set up in a renovated brick yard, an abandoned fire station, remodeled military barracks, various warehouses and a converted mortuary.

In 1962 the consulting firm of Lester Gorsline Associates made a long-range survey of the Medical School's needs and arrived at a multiphased developmental program. It called for an initial five-story basic science building, to be followed by the development of separate buildings to house a vivarium, library, auditorium, and the clinical science departments. Because of the many demands on

Dr. Papper is Vice President for Medical Affairs and Dean of the University of Miami School of Medicine, and Dr. Fogel is Assistant Vice President for Medical Affairs.



Fig. 1.—Original medical school building in September 1952. A three story, pseudo Spanish colonial style structure, built as quarters for the domestic staff of the adjacent Biltmore resort hotel which opened in 1926. Basic science classes were held here until 1969 when the Rosenstiel Medical Sciences Building was opened.



Fig. 2.—Bascom Palmer Eye Institute

University funds, it became apparent that separate buildings for the basic and clinical science departments and a vivarium would not be constructed. Therefore, a decision was made to complete the exterior construction of an additional three stories on the Rosenstiel Medical Sciences facility to be used by the clinical science departments, and incorporate the vivarium throughout the building. The upper three floors of the Medical Sciences Building were completed in 1973 (Fig. 4) and for the first time since the School's opening in 1952, the institution was physically unified in the medical center with its primary teaching hospitals.

In 1968 a new 750 bed Veterans Administration Hospital was constructed west of Jackson Memorial Hospital on Twelfth Avenue (Fig. 5). This hospital has become an integral part of the University of Miami Medical Center and has served as a vital resource from a service, research and educational standpoint. Today the VAH has one of the best records for clinical service in the nation, and



Fig. 3.—University of Miami Hospital and Clinics.

is among the top five supported by Veterans Administration Research Grants.

In June 1968 construction began on the Mailman Center for Child Development (Fig. 6). This facility is presently the focal point of an extensive multidisciplinary approach to the problem of child development. The Center, a $6 million, eight-story tower with adjoining two-story building, was opened in March 1971.

On January 6, 1971 groundbreaking was held for the Louis Calder Memorial Library (Fig. 7). This building was dedicated on March 19, 1972. The Library is a three-story structure containing 50,197 gross square feet with a volume capacity of 120,000 and 38,818 linear feet of shelving. It has a seating capacity of 323. Currently, the Library contains nearly 100,000 volumes and subscribes to some 1,800 domestic and foreign journals. A special History of Medicine Collection is housed in the larger third-floor Conference-Lecture Room. The Library is part of the Medical Literature Analysis and Retrieval System tied in directly to the National Library of Medicine in Bethesda, Maryland, with a completely computerized hookup known as MEDLINE. It serves as a resource to all physicians in South Florida.

Early in 1976 the 14-story West Wing Building of Jackson Memorial Hospital will be opened. This unit will provide 370 new patient beds and permit the demolition of Skaggs, Woodard and East Wing buildings. Later in 1976 ground will be broken for the new seven-story ambulatory care building which will be a part of the second phase of construction. We are optimistic that by 1979 the old Jackson Memorial Hospital will have been replaced by a modern health facility that will complement the exceptional talents of the professional people and their associates and assistants in our Medical Center.

Achievements

Despite the initial makeshift physical facilities and the lack of adequate financial resources, the University of Miami School of Medicine achieved in 23 years a position reached by most medical schools only after many decades of effort. The development of one of the nation's foremost medical centers is partial evidence of the School's remarkable progress. The School has also clearly demonstrated its ability



Fig. 4.—Rosenstiel Medical Sciences Building.

to recruit an outstanding faculty of nationally and internationally recognized educators, scholars, scientists, and clinicians. It has established an excellent medical education program, become a leader in biomedical research, and is responsible for the health care delivery of a sizeable portion of both the public and private patients of Dade County, South Florida, and the Caribbean area.

A brief perusal of an institutional profile provided by the Association of American Medical Colleges for the years 1973-1974 provides further evidence of the prominence of the state's first School of Medicine. At the present time, the faculty of the School of Medicine is responsible for the training of the eighth largest intern and resident staff in the nation. Our faculty supervises the professional aspects of the largest medical center in the southeastern United States; the fifth largest in the nation. The regular operating expenditures of the Medical Affairs Division for this year will be nearly 50% of the total operating expenditures of the entire University, the tenth largest of any school of medicine in the nation. As of 1974, the School had the 14th largest full-time faculty and a volunteer clinical faculty membership of nearly 1,000. In an era of increasing competition for federal dollars, the School of Medicine ranked 20th among all the nation's medical schools in total sponsored research and training, and 17th in recovery of federal indirect costs. These data are reflected in the fact that the University of Miami has become 29th among all the nation's universities and colleges in receipt of federally sponsored programs. This accomplishment is especially significant when one considers that the Medical Affairs Division does not have schools of dentistry, veterinary medicine, pharmacy or public health or a major outreach rural health care program.



Fig. 5.—Veterans Administration Hospital.



Fig. 6.—Mailman Center for Child Development Building.



Fig. 7.—Louis Calder Memorial Library.

The total number of students, undergraduate, graduate, and housestaff, ranks this School of Medicine as the 17th largest medical training center in the United States. Total sponsored program expenditures were the 17th largest of any biomedical institution in the nation. The School was 22nd in expenditures for undergraduate medical students. Over 40% of the alumni were in primary care practice and the majority of our graduates have established practices in the State of Florida. These credentials coupled with the excellent performance of our undergraduate students on the National Boards of Medical Examiners, and our graduates' ability to obtain their first or second choice in the Intern and Resident Matching Program, emphasize the rapid progress achieved by a School of Medicine with virtually no endowment, a minimal amount of private support, and a major dependence on the imponderables of federal, state and local government funding.

Despite the complex problems facing every school of medicine in the nation today, we are optimistic that the University of Miami School of Medicine will continue its quest toward excellence and to be a credit to itself and the State of Florida which has been so supportive of its development.

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Medical Students

Those familiar with students at the University of Miami School of Medicine have noticed a gradual change in their characteristics during the past several years. Although it is impossible to describe a typical student, some broad generalities may be pertinent. The following report is based on interviews with a number of medical students, principally Ted Silver, Jeff Hammond and Larry Ashbacher, Class of 1975; Grace Wang, Class of 1976; Richard Bosshardt, Class of 1977, as well as several members of the faculty and administration.

In the late 1960s, veterans of a decade of student unrest and activism on college campuses began appearing at the University of Miami and all other medical schools. They brought with them a less conservative lifestyle and, as much as possible within the rigid confines of medical curriculum, a "Let it all hang out" philosophy. Now another cycle is under way. There are differences between the two generations, some manifest, some subtle. There are also similarities. Here are some observations from those currently on the scene.

Activism

The Class of 1972 appeared to be the breakoff between the activists of the 60s and today's more conservative students. "Many were nonconformists who would protest about almost anything. Whatever it was, they were against it," says a faculty member.

Fortunately, a critical attitude on the part of students still exists. They do not hesitate to voice their opinions; not only among themselves, but to their mentors. Seniors, many of whom have had an opportunity to visit other medical institutions around the country, have well thought out concepts of the strengths and weaknesses of the curriculum at our own and other schools. They rank the University of Miami School of Medicine's training program very high overall, but are cognizant of some deficiencies. Appropriately, they have worked with the faculty and administration to strengthen the entire program in order to make it one of the best in the nation.

"I know of only one instance in which we felt the instructor didn't have enough knowledge to teach," said one senior. "Some instructors were knowledgeable but unable to communicate, or taught inappropriate material, or had difficult accents. The usual way of showing disapproval was poor attendance, although occasionally students hissed after a poor educational experience." "The vast majority of students, however, are extremely courteous and express more appreciation than criticism," observed a faculty member who has had considerable contact with the student body.

A senior sees the difference between today's students and those of three or four years ago as lying in interests. "It's a difference in academic preparation," he said. "Today's students are aggressive medically, but not as intellectually aggressive. They're interested in taking on extracurricular activities, like working in the wards. This is good in a way, but it takes their minds off learning activities."

Motives

What prompts students to enter the field of medicine? The majority of successful applicants, say those close to the admission process, find it difficult to verbalize a reply to this question. It's something innate, like preferences in colors or tastes, or for certain people or ways of doing things. "I just couldn't picture doing anything else," they'll answer, looking puzzled.

Fundamentally, they share a common, overwhelming concern for the health of their fellow humans. Some might, as expected, have parents or relatives in the medical or paramedical professions. Some have been impressed by the "miracles wrought" by physicians who attended ill or injured members of their families. Others have been intrigued by the exactitudes of physical science, but found it repellently cold without a human element.

"Sure, I'm the stereotype—two generations of physicians, plus uncles, and a mother who was in nurse's training when she married Dad."

"My aunt was dying, we lived out there in the country, but the Doc, he came, he saved her; I never forgot that; he was the most revered person around; I can't think of anything more important than making people well."

"I have an engineering degree, but the work was impersonal. I did some biomedical engineering and made up my mind to be a doctor-interested-in-engineering rather than an engineer-interested-in-life-sciences."

"Originally I wanted to do biomedical research, but switched to medicine when funding decreased. I'm glad I did. Right now I'm fascinated by surgery."

Specialization

This decision appears to come late in the students' undergraduate medical career. As students rotate thorugh the various specialties and subspecialties, they rule out some and are intrigued by others. Professors advise students not to make early choices, and most students take the advice.

"As a freshman, you have anywhere from five to six years to make up your mind," observed a first-year man. Primary Care is popular. An interviewer reported that out of hundreds of applicants queried, all but a dozen indicated they were interested in the primary care fields.

A senior said he thought family medicine complicated the selection of a specialty. "In the past it was easier to decide the type of practice you wanted," he said. "Then a senior could plan to go into general practice and be out in the community within a year. Family medicine has reversed this. You have to take advanced training to go into family medicine now."

Women students, who traditionally have specialized in pediatrics or ob-gyn, are going further afield. "I thought sure I'd go into internal medicine," said one female student. "But now I like surgery—there's an extra challenge to a girl's going into surgery. I haven't heard of any girls going into orthopaedics yet, but maybe some day they will."

Location of Practice

This is another selection which frequently is held in abeyance. However, most students who come from small communities say they'll probably go back. Statistics obtained in a comprehensive alumni study substantiate that this is generally the case. Those who are undecided take the same attitude they do about a specialty—there's plenty of time to decide.

Attitude Toward Government Programs

Government sponsored programs enjoy a mixed popularity among the students. Undoubtedly, much of this is a result of the current economic situation. The UMSM always has been among the most active in the Navy's medical training program which provides tuition, together with pay and other prerequisites in return for commitments to naval service. About 40 students are currently in the program; about ten each are in similar programs offered by the Army and Air Force. A number of our students are West Point graduates.

The Public Health Service has five scholarship programs designed to aid areas with physician shortages, and the National Health Service Corps offers a voluntary program under which students receive a year's tuition for each year they agree to serve in rural communities. "We have many applicants for these positions," said a student advisor.

The students do not mind these voluntary programs, but they are concerned with the talk in Congress of making service in undermanned areas compulsory in return for government funding of institutions. This attitude is indicated by the decline in Student American Medical Association membership due to a report — erroneous — that SAMA favored government service. "The membership went down and didn't come back up, but now we're actively recruiting," said a junior student.

The average student shows little interest in government health legislation. "Few students have an understanding of the Professional Standards Review Organization, for example," said a senior. "MedApprentice (the student newspaper) has started a Legislative Affairs column for those who are interested and to spark interest among others. I think right now the students are more concerned with their education than bothering about these things."

Personal Appearance

The handful of "Hairy Eggs" or "Bearded Billiard Balls" who were a little more common a few years ago—scalp and facial hair equally long and woolly, punctuated only by eye-mouth-and-nose holes —have disappeared. Hair remains on the long side, but neat and sometimes "styled." The crew cut hasn't returned—yet. Beards are vestigial, or more frequently limited to neatly trimmed mustaches, which are popular.

The "kempt" look is not always spontaneous, but extraneously prompted, particularly by patient pressure.

"Long hair is highly individualized. In general, when you go to patients, you clean up."

"When I became a junior, all of a sudden my long-haired classmates became short-haired; I didn't recognize some of them."

"All I needed was a patient to cringe from me and say, 'You're not going to touch me'."

"When you get into surgery, you realize it's ridiculous, unsterile. So you shave off your beard and trim your hair."

Dress

The sloppy "hippie" look—faded, ragged, cut-off blue jeans and T-shirts—is out. Casually conservative attire is in—slacks and shirts and more and more frequently, neckties are in evidence. For the women, dresses or skirts, or more frequently pantsuits. The white jacket is almost always present and is worn by both sexes over street clothes.

In a gesture reminiscent of young actors and actresses who eat in full make-up and costume at Broadway lunch counters, gung-hos rotating through surgery stroll the campus in surgical green, complete with skull caps and bound-up shoes.

"You see blue jeans and T-shirts only in the basic science. They're not worn in the hospital."

"Some Old School professors try to tell you how to dress, like 'Wear a white jacket,' but usually you wind up wearing what makes you and the patient most comfortable."

"At my previous school, dress was regimented; we were all issued brown lab coats."

"You've got to conform to the stereotype role a little — the Man in White. You can't go around looking like Alice Cooper and expect to treat patients."

An interviewer predicted even more formalization of dress among future freshmen. "Everywhere we went on our last interviewing trip, students came well dressed and on time. The men wore neckties and in many cases suits and vests. Nobody was in cut-offs and sandals."

Conclusion

These observations are not unique to the University of Miami School of Medicine but are applicable to every medical school campus in the nation. We at the School of Medicine have actually had little real "activism" and, in most instances, it was warranted. The fact is that we have an excellent student body. They are dedicated to human service, have tremendous intellectual abilities, exemplify fine personal qualities, and will ultimately become fine, compassionate, devoted physicians who will reflect well on the profession.

FOREIGN EDUCATIONAL PROGRAM NEEDS VOLUNTEERS

Would you like to take a month off and help train foreign doctors in their native lands?

If so, MEDICO, a service of CARE, could use you. The program assigns volunteers to help train young men and women in their particular branch of medicine or surgery. Openings are available in Afghanistan, Bangladesh, Dominican Republic, Indonesia, Jordan, Nicaragua and Tunisia.

Volunteers pay their own travel and maintenance costs, which may be tax deductible.

Information about the program may be obtained from George B. Mathues, Director, MEDICO Volunteer Specialists, 2007 Eye Street, N.W., Washington, D. C. 20006.

The Research Program of the University of Miami School of Medicine

William J. Harrington, M.D. and Gerald S. Atchison

The University of Miami School of Medicine is now among the best nationally in areas such as cancer research, clinical and basic research, and in new teaching techniques.

Founded only 24 years ago, the School is ranked 17th out of 125 medical schools in the United States in terms of grants received for basic and applied research. It has over 500 full-time faculty members and a medical student enrollment of more than 650. One hundred twenty-seven senior faculty are engaged full time in research. The excellence of this scientific community has enabled the University of Miami to remain among the most competitive nationally, despite a decrease in federal support.

To coordinate this search for support, in 1973 the School established an Office of Research Administration to keep the faculty informed of agencies affecting funding. With other schools, this School has experienced a shift from federal to nonfederal sources. Federal support declined by 6.8% in 1974-1975. But the total value of awards from all sources increased by $1.1 million. The Department of Health, Education, and Welfare provided 70.8% of all awards, with N.I.H. the largest single source (43.3%). Direct expenditures increased by 11.8% and indirect costs rose to nearly $1 million.

Outlays for health care in the United States are exceeded only by those for defense and education.

There are many directions which have been taken by the University of Miami. Among these, the School of Medicine has sponsored such projects in technology as the development of fluorescent antibody and immunodiffusion tests for the rapid detection of in utero viral infections and a rapid, simplified procedure for radioimmunoassay of body levels of polyamines, addictive drugs, steroids, and nicotine. The School has also explored the use of Staphylococcus aureus (Cowan I) and its protein-A as diagnostic tools and the development of new chemotherapy methods for specific blood detoxification using an extracorporeal shunt chamber. Another diagnostic problem relating to blood being examined at the School of Medicine is the development of a radioimmunoassay for typing human hemoglobin genetic variants.

Heart and lung diseases are areas of intensive research; the development of methods for the micro-immunologic detection of pulmonary infections and the design of a test for assessing the risk of heart attack in persons having "normal" cholesterol levels are high-priority projects.

Methods for dealing with venereal disease — especially gonorrhea — are under study, such as a rapid, specific radioimmunoassay for gonococcal antigens in patients infected with Neisseria gonorrheae. There are projects relating to Candida albicans, serum alpha-amylase, the isolation and purification of tumor antigens for CEA detection, and the detection of genetic variants of enzymes and proteins for forensic science. The School of Medicine is capable of producing blood parasites in volume and has developed methods for the preparation of parasite antigens.

The circulation is the subject of many studies. Investigation of the portal circulation comparing conventional dye dilution methods with other techniques for measuring blood volume and blood flow (such as thermister, isotopic, and catheter-probe methods) is a major project now underway at the School, as is the development of instrumentation for transhepatic catheterization of the portal system. The effects of drugs on portal circulation before and after shunt procedures is being studied, and the effect of ion-selective ionophores on cardiac contractility and coronary blood flow is being examined as part of an overall evaluation of heart function. Prostaglandins and adenosine in blood — especially in coronary circulation — are being studied in dogs. Cerebral circulation and the management of strokes has been long studied here.

Dr. Harrington is Professor and Chairman of the Department of Medicine at the University of Miami School of Medicine, and Mr. Atchison is Associate Dean for Research Administration.

The interaction of drugs with bone marrow cells is under examination, as are the effects of cyclic AMP and RNA on syntheses in rat liver and on production and mechanism of action of erythropoietin.

In dental and oral health, several studies are underway which examine the role of polysaccharides and bacterial enzymes in dental plaque formation, and of antimicrobial agents for control of caries and periodontal disease. Biochemical and animal studies are being carried out on bacteriological and nutritional factors in caries. A process for production of alpha-1,3 glucanase is being developed for the prevention of caries.

The School also conducts research on human skin. Current work includes measurement and control of percutaneous absorption and skin barrier properties; topical drug formulation and vehicle effects; prophylaxis and treatment of poison ivy dermatitis with topical agents; investigation of the role of prostaglandins in cutaneous inflammation, including ultraviolet damage; and evaluation of sunscreening agents and anti-inflammatory agents in vivo.

One of the most preplexing dilemmas in industrialized society is the protection and preservation of the environment. Modern life requires mass production of more goods. At the same time there is a limit to human tolerance of industrial wastes and occupational hazards. The School is deeply involved in the protection of people while advancing technology in the use of resources.

One major area of work now going on involves comprehensive investigations of pesticides. The year-round growing season permits an exceptional level of research in this field. Studies include development of methods for determination of pesticide degradation products and other toxic substances and the design of comprehensive, multiresidue, analytical methodologies, as well as identification of toxicants in environmental samples by gas chromatograph and spectrometry. Research on pesticide and herbicide degradation is linked with that on methodologies for determination of exposure and training of personnel in pesticide control.

Worker exposure to pesticides is reduced by silicone treatment of clothing. The Department of Epidemiology and Public Health has analytical residue laboratories. Information has been collected on the frequency distribution of the incidental exposure of the general population to a wide variety of environmental pollutants. DDT and dieldrin have been studied in 122 cases and controls; similar approaches are being applied to chlordane and heptachlor. The Department is now ready to investigate the epidemiological consequences of carcinogenic materials in water. Collaboration for these studies is provided by the Division of Biostatistics, whose personnel have had long experience in chronic diseases (particular cancer and cardiovascular). A Univac 1106 computer is provided by Dade County for these activities.

The School of Medicine is also interested in development of alternative ways of disposal of a wide range of waste materials. Some researchers take this one step further and seek new uses for what were previously considered to be waste products; for instance, ways to utilize agricultural waste materials for the production of amino acids, lipids, natural food colorants, protein enrichment of high carbohydrate foods, single cell proteins, and enzymatic conversion of urban solid, as well as agricultural wastes to ethanol. Efforts are also underway to isolate lignin-degrading organisms as a source of an active enzyme for use in the processing of wood products and waste. Tied in with this work is the production of cellulases for application to wood pulp processing and paper manufacture.

Research into basic biological sciences branches out in several directions at the University of Miami's School of Medicine. Cancer research, methods for the detection of viruses in environmental waters, the development and evaluation of biological pesticides, and many other studies make up an impressive portfolio of activities which may have applications in a number of areas.

In cancer research, the School of Medicine is involved in several investigations of tumor immunology, including spontaneous cancers in patients and experimental models of virus-associated and/or chemically induced tumors in animals. Researchers are also involved in biological in vitro screening of new drugs with potential usefulness in cancer therapy and of carcinogenic environmental pollutants. Research on chemotherapeutic agents and their associated immunosuppressant activities is being carried out in conjunction with the determination of immune status and the effect of immunoprophylaxis in human and animal cancer. The isolation and characterization of antibacterial, antiviral, and immunosuppressant substances from marine sources is another aspect of this work. The University of Miami's School of Medicine is also examining the role of N-oxidation of the primary aromatic amines in bladder carcinogenesis.

The Department of Ophthalmology is regarded

as one of the best in the United States in clinical care and research.

In addition to these programs and facilities, the University of Miami School of Medicine has several major, interdepartmental research and treatment centers, existent or under development, which inestimably enhance its research, medical care, and education.

Comprehensive Cancer Center for the State of Florida

Two of the most prominent men in the field of cancer treatment and research were recruited by the University of Miami's School of Medicine to head the Cancer Center, now in the third year of operation. Dr. C. Gordon Zubrod, Director of the Center and Chairman of the newly established Department of Oncology, came to the University following a long and prestigious career at the National Cancer Institute as Director of the Division of Cancer Treatment and Scientific Director for Chemotherapy. Dr. Alfred S. Ketcham, Chief of the Division of Surgical Oncology, was also recruited from N.C.I., where he was Clinical Director and Chief of the Surgery Branch and Associate Director of the Clinical Research Division of Cancer and Biology Diagnosis.

On an annual budget of $1.2 million, the Cancer Center provides a nucleus of key, full-time staff which serve as a focal point for cancer research, education, and patient care through interdisciplinary collaboration by disease-oriented teams within the University. In the community, the Center provides leadership through education and demonstration and the marshalling of resources and support for cancer research and patient care.

In addition to the 16-member faculty of the Department of Oncology, 30 faculty members of other departments are active in the Center, serving on Center boards or conducting Center-supported research. A Grant Review Committee provides peer review of most cancer-related grants and contracts submitted from the School of Medicine; several pilot projects are funded annually to encourage the development of solid, long-term research programs by new investigators. The major areas of research pursued with the Center's support include cancer detection, diagnosis, treatment, and rehabilitation.

The presence of the Cancer Center at the University of Miami has spurred the rapid expansion of a statewide cancer education program for Florida physicians, dentists, nurses, and pharmacists. Oncology specialists present recent advances in cancer research and treatment in seminars at community hospitals, medical societies, and health departments. Table 1 describes the progress of the professional and public education program.

Specialized Center of Research for Atherosclerosis in Childhood

In its fifth year of funding by the National Heart and Lung Institute, with an annual budget of $500,000, the University of Miami's Center is uniquely oriented toward pediatric research. Under the direction of Dr. Mary Jane Jesse, the Center's primary objective is investigation of the underlying metabolic factors which may lead to increased risk of coronary heart disease. The general hypothesis being tested is that patterns of risk factors in adults are identically manifested in their offspring.

One hundred fifty families are enrolled in a longitudinal clinical study to determine whether children of parents who have had premature myocardial infarctions are different from children of matched control families. Risk factors explored include serum lipids, blood pressure, carbohydrate metabolism, and physical characteristics. In addition, infants of two hundred forty-three "high-risk"

TABLE I.—Growth of On-Site Cancer Education Program

	1970-71 1971-72	1972-73	1973-74	1974-75
Organizations	7	16	39	86
Programs	19	33	56	162
Lecture Topics	38	53	96	279
Credit Hours	48	80	125	348
Total Audience	590	1,620	2,709	8,101
Hours Completed*	1,770	4,680	8,292	25,716

*Credit hours x audience count for individual programs totalled for the year.

mothers identified during their pregnancy have been studied in an effort to determine whether the well-known phenomenon of familial aggregation of blood pressure begins in early infancy.

The Center has been nationally recognized through a public television network program on coronary heart disease and a National Broadcasting Council program about pediatric atherosclerosis.

Comprehensive Sickle Cell Center

The $1.6 million, five-year award to the University of Miami for this Center was one of five granted by the National Heart and Lung Institute in 1973. The purpose of these Centers is to generate both basic and clinical research in sickle cell diseases; to foster paraprofessional and professional awareness and understanding of this group of diseases; and to develop programs for public education, accurate diagnosis, and genetic counseling for the community. The Director of the Miami Center is Dr. Donald R. Harkness, Professor of Medicine and Biochemistry. The principal investigator for screening and education programs is Dr. John E. Davies, Professor and Chairman of the Department of Epidemiology and Public Health.

Five community health-care facilities participate in the screening program by collecting blood specimens for their registered patients. These samples are sent to the screening facility for laboratory diagnosis of hemoglobin abnormalities. Follow-up (including education, counseling, and referrals when indicated) is conducted by genetic counselors in coordination with the health-care agency.

The Sickle Cell Clinic of Jackson Memorial Hospital provides medical care for 25 to 35 adults and children with sickle cell diseases each week, with assistance from faculty of the Department of Pediatrics and fellows from both Pediatrics and Medicine, who handle emergency-room consultations and hospital services. Two social workers counsel both outpatients and inpatients and their families. The Clinic not only offers specialized patient care, but also provides an ideal setting for instruction of medical and nursing students and an adequate number of patients for clinical studies.

Mailman Center for Child Development

Established in 1972, the Mailman Center receives $1.6 million annually in sponsored funds. The Director (and Vice Chairman of the Department of Pediatrics) is Dr. Robert Stempfel, Jr., formerly Chairman of the Department of Pediatrics, University of California at Davis. The principal focus of the Center's programs is early detection and prevention of developmental disabilities and comprehensive evaluation and care.

Dr. Stempfel has spearheaded growth of this program in three directions: 1. A preliminary evaluation program has been developed as an extension of the intake clinic; initial evaluation by a primary physician, supported by screening services, is followed by definitive appraisal by specialty areas and management planning through staff conferences; 2. The long-term follow-up program emphasizes early handicap detection and data retrieval for investigations of populations at risk; of fundamental importance to this program has been development of the Division of Perinatology, coordinating the efforts of the Departments of Pediatrics and Obstetrics and Gynecology with those of the Mailman Center; 3. The Center is developing an infant, toddler, and preschool intervention program for children identified as potentially or frankly retarded.

In advanced stages of development are centers for renal diseases (Dr. Neal S. Bricker), blood diseases (Dr. Adel A. Yunis), diabetes (Dr. Daniel H. Mintz), and pulmonary diseases (Dr. Donald J. Massaro), with their distinguished faculty awaiting well-designed facilities now under construction.

We have mentioned some of the research programs and facilities which make the University of Miami School of Medicine one of the finest medical schools in the United States, a School now ready to assume its natural role as leader in Inter-American medicine.

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Reason clears and plants the wilderness of the imagination to harvest the wheat of art.—Austin O'Malley

The University of Miami School of Medicine's Alumni During the School's First Twenty Years

Marilyn Mendelson, Ph.D., Bernard J. Fogel, M.D., John K. Robinson, M.D., and Emanuel M. Papper, M.D.

This report concerns the University of Miami School of Medicine (UMSM) and its alumni during the first 20-year period of the School. The graduating years dealt with in this report range from 1956 to 1973 during which time 1,251 medical students were graduated. Another 289 students were awarded the M.D. degree in 1974 and 1975 but are not included in this report because distribution trends for the latter group have not been developed as yet.

Various data concerning the Medical School programs and the alumni covering this time period were collected and form a substantive body of information. The scope of this paper is limited to two categories of data. The first subset examines the following issues of particular interest to the practicing physicians of Florida:

1. The internship and residency distributions of alumni by state, Florida county, and medical type.

2. The private practice distribution of alumni by state, Florida county, and medical type.

The second concern of this report is to examine all of these distributions in order to determine if any time trends exist and what can be learned from them.

A final subset of data deals with academic correlations. These will be published at a future date and should be of interest to medical educators.

Categorization of Data

To facilitate the discussion, analysis, and interpretation of the numerous data, several data categories were established. At times throughout this report, data are classified according to (A) geographic categories, (B) Florida county categories, and (C) medical type categories.

(A) **Geographic Categories** — Five geographic categories were established. The first four refer to geographic regions of the United States, and the last refers to other countries. These five are: South (nine states), East (15 states), Central (14 states), West (13 states), and Outside USA. In the geographic categories as well as in the other categories that follow, it should be noted that not all components of each category are necessarily represented in each topic area. (For example, the state of Maine is a component of the eastern geographic category; however, no alumni were residents of Maine at the time of their entry into the UMSM.)

(B) **Florida County Categories** — Florida counties were categorized by population size on the basis of their population in 1960. To determine the applicability of these 1960 statistics for the complete time range with which this study deals, Pearson product moment correlation coefficients were run comparing the 1960 population figures with the 1950 and 1972 figures.

The correlation of county size from 1950 to 1960 was .975; the correlation of county size from 1960 to 1972 was .984. These high almost perfect correlations indicate that although counties changed in size through the 20-year period, they basically maintained the same ranks through the years in relation to one another. Counties which had the smallest population in 1950 tended to be smallest in 1960 and 1972. These strong relationships justified the categorization of Florida counties according to their population size in 1960.

Five categories based on 1960 census statistics were established:

1. Counties over 85,000 in population.
2. Counties having from 60,001 to 85,000 in population.
3. Counties having from 35,001 to 60,000 in population.

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States of Residence of Alumni Upon Entry to UMSM

The distribution of alumni according to their home states at the time of their entry into the UMSM is shown in Table 1.[1]

Table 1.—Distribution of 1,251 Alumni According to Their State of Residency Upon Entry to UMSM.

Geographic Area	Frequency of Alumni	%	State	Frequency of Alumni	%
South	1,179	94.4	Alabama	2	.2
			Florida	1,173	93.8[2]
			Georgia	2	.2
			North Carolina	1	.1
			Tennessee	1	.1
East	33	2.8			
Central	16	1.4			
West	9	.8			
Outside USA	9	.8			
Data Unavailable	5	.4			

1 Rounding errors resulted in some minor discrepancies in the reported percentages in this table and others to follow.
2 The past three entering classes have contained more than 98% Florida residents. Thus over 95% of all entering students at the UMSM were from Florida.

4. Counties having from 10,001 to 35,000 in population.
5. Counties under 10,001 in population.

(C) **Medical Type Categories** — Medical types by which internships, residencies, and private practices were identified were classified according to two categories: primary care and specialty care. For purposes of this report, Primary Care is defined as Family Medicine, General Practice, General Medicine, and Pediatrics. The components of speciality care are not listed in tabular form but are well known to all readers. Although traditionally considered in the category of Primacy Practice, Obstetrics and Gynecology was classified under specialty care.

Florida Counties of Residence of Alumni Upon Entry to UMSM

In Table 1 it was shown that 1,173 alumni of the total of 1,251 alumni (through 1973) were Florida residents at the time of their entry into the UMSM. The by-county distribution of these 1,173 is given in Table 2. In Table 2, the counties are both categorized according to 1960 census population figures and presented according to their ranks in population size. A rank of 1 was given to the county with the largest population; a rank of 2 to the next largest county, and so on. Since no two counties had exactly the same population in 1960, these ranks were untied. The range of population ranks is 1-53, as 53 of the 67 Florida counties are represented in this distribution.

Counties were also ranked in terms of the number of alumni who were county residents upon UMSM entry. These ranks, determined by alumni frequency, appear as tied ranks when the frequency of alumni is the same for more than one county. Thus, alumni frequency ranks 17-23 are tied ranks.

To illustrate the reading of Table 2, the first entry shows that Dade was given a population rank of 1 (Dade was the largest county in population in 1960 and 1972), and a rank of 1 for alumni frequency (more alumni were residents of Dade upon UMSM entry than of any other county). Of the 1,173 alumni who were Florida residents, 524 (or 41.9% of the total distribution of 1,251 alumni) were residents of Dade County. Although this percentage may be considered high, it is in fact low when one considers that more than 50% of Florida resident applicants are from Dade County, and that the County's population of 1,342,475 (1972) is over 20% of the entire State. Moreover, in-

Table 2.—Distribution of Alumni According to Florida Counties of Residence Upon Entry to UMSM.

County	Rank in Population Size-1960	Rank in Alumni Frequency	Frequency of Alumni	% of Total Alumni
Category 1: Counties over 85,000 in population				
Dade	1	1	524	41.9
Duval	2	5	47	3.8
Hillsborough	3	3	83	6.6
Pinellas	4	6	39	3.1
Broward	5	2	111	8.9
Orange	6	7	37	3.0
Palm Beach	7	4	62	5.0
Polk	8	8	33	2.6
Escambia	9	11	21	1.7
Volusia	10	10	23	1.8
Brevard	11	15	10	.8
Category I Total			990	79.1
Category 2: Counties 60,001—85,000 in population				
Sarasota	12	13	12	1.0
Leon	13	14	11	.9
Alachua	14	9	29	2.3
Manatee	15	17	7	.6
Bay	16	20	4	.3
Okaloosa	17	21	3	.2
Category 2 Total			66	5.3
Category 3: Counties 35,001—60,000 in population				
Lake	18	19	5	.4
Seminole	19	16	8	.6
Lee	20	20	4	.3
Marion	21	18	6	.5
Monroe	22	12	13	1.0
Gadsden	23	20	4	.3
St. Lucie	24	17	7	.6
Pasco	25	22	2	.2
Jackson	26	20	4	.3
Category 3 Total			53	4.2
Category 4: Counties 10,001—35,000 in population				
Putnam	27	22	2	.2
St. Johns	28	19	5	.4
Indian River	29	22	2	.2
Highlands	30	21	3	.2
Columbia	31	23	1	.1
Clay	32	22	2	.2
Osceola	33	23	1	.1
Nassau	34	20	4	.3
Martin	35	22	2	.2
Collier	36	18	6	.5
Walton	37	22	2	.2
Suwannee	38	21	3	.2
Madison	39	22	2	.2
Charlotte	40	22	2	.2
Bradford	41	22	2	.2
Hardee	42	21	3	.2
Sumter	43	23	1	.1
DeSoto	44	23	1	.1
Washington	45	23	1	.1
Category 4 Total			45	3.6
Category 5: Counties Under 10,000 in population				
Gulf	46	22	2	.2
Jefferson	47	22	2	.2
Hendry	48	21	3	.2
Hamilton	49	23	1	.1
Calhoun	50	20	4	.3
Okeechobee	51	21	3	.2
Union	52	22	2	.2
Glades	53	23	1	.1
Category 5 Total			18	1.4
County Unknown			1	.1
Out of Florida State			73	6.4
Data Unavailable			5	.4

dividuals from counties near the University of Florida College of Medicine and the University of South Florida College of Medicine tend to enroll in these fine institutions.

The magnitude of statistical correlation indicates that the relationship between county size and county frequency of alumni is high and positive; that to a fair dgree counties are contributing alumni in numbers proportional to their relative population size. Discrepancies between the two assigned ranks may well be related to the geographic location of counties and their proximity to other Florida medical schools.

A summary of the information given in Table 2 for the 1,173 alumni who were Florida residents at the time of their entry to UMSM shows that:

1. 990 were residents of counties over 85,000 in population.
2. 66 were residents of counties 60,001 — 85,000.
3. 53 were residents of counties 35,001 — 60,000.
4. 45 were residents of counties 10,001— 35,000.
5. 18 were residents of counties under 10,001 in population.
6. The resident county of one Florida alumni was unidentified.

The data indicate that 79.1% of the alumni group were residents of Florida's 11 largest counties at the time of their entry into medical school. The other 42 smaller counties from which alumni came accounted for another 14.5% of the total alumni group.

Florida County of Residence and Location of Private Practice

The alumni's counties of residence at UMSM entry were examined with reference to the later geographic locations of their offices of private practice. Records showed that 597 (47.7%) of the 1,251 alumni had established offices in the United States at the time data were compiled in the fall of 1973 and had also reported the location of their practices.

It should be recognized that many alumni of the last several graduating years (1969-1973) were still in their internships, residency programs or the Armed Forces at the time of data compilation and had not yet had the opportunity to establish practices. This factor accounts for what may seem to be an excessively small percentage of alumni in private practice. This limitation is encountered

in all aspects of such reports that incorporate private practice variables as well as residency variables.

The classification of alumni by Florida counties of residence and geographic location of their offices of practice is given in Table 3. A brief discussion of Table 3 is presented here to facilitate its interpretation. Two variables are presented in matrixes of this form. In this case, the two variables are "Florida County of Residence" (row entries) and "Geographic Area of Practice" (column entries).

Each variable of the matrix has several categories or levels. Those for Florida counties are: an unidentified level, called "Missing or Not Applicable;" and the identified categories: Categories 1-5. The levels for geographic area of practice are: Missing or Not Applicable; and the identified levels: East, South, Central, and West.

The missing categories account for those alumni who could not be classified by the identified categories, either because of an incomplete data base, or because (as with the private practice variable) these categories were just not applicable.

Two sets of marginal entries are given for tables of this form: row total entries and column total entries. At their intersection at the bottom right of the table, we find the frequency 1,251 (100% of the total alumni group). Row totals for Table 3 are read as follows: 79 (6.3% of 1,251) alumni were not classified by Florida county of residence; 990 (79.1% of 1,251) were in County Category 1; 66 (5.3% of 1,251) were in Category 2; and so on. Column totals are read similarly: 654 (52.3% of 1,251) alumni were not classified by geographic area of practice, 54 (4.3% of 1,251) were in the East category, etc.

The cells of the matrix are formed by the joint occurrence of a category of one variable with a category of a second variable. The legend at the bottom left of Table 3 is used to interpret the nu-

Table 3.—Distribution of Alumni by Florida Counties of Residence Upon Entry to UMSM and Later Geographic Locations of Office of Practice.

Florida County of Residence	Missing or not Applicable	1 East	2 South	3 Central	4 West	Row Total
Missing or Not Applicable	60 75.9 9.2 4.8	5 6.3 9.3 .4	8 10.1 1.8 .6	1 1.3 5.0 .1	5 6.3 7.2 .4	79 6.3
Category 1 Over 85,000	515 52.0 78.7 41.2	43 4.3 79.6 3.4	359 36.3 79.1 28.7	15 1.5 75.0 1.2	58 5.9 84.1 4.6	990 79.1
Category 2 60,001 to 85,000	37 56.1 5.7 3.0	1 1.5 1.9 .1	24 36.4 5.3 1.9	3 4.5 15.0 .2	1 1.5 1.4 .1	66 5.3
Category 3 35,001 to 60,000	20 37.7 3.1 1.6	3 5.7 5.6 .2	27 50.9 5.9 2.2	.0 .0 .0 .0	3 5.7 4.3 .2	53 4.2
Category 4 10,001 to 35,000	15 33.3 2.3 1.2	1 2.2 1.9 .1	26 57.8 5.7 2.1	1 2.2 5.0 .1	2 4.4 2.9 .2	45 3.6
Category 5 Under 10,001	7 38.9 1.1 .6	1 5.6 1.9 .1	10 55.6 2.2 .8	.0 .0 .0 .0	.0 .0 .0 .0	18 1.4
Column Total	654 52.3	54 4.3	454 36.3	20 1.6	69 5.5	1251 100.0

Legend: Frequency
Row Percentage
Column Percentage
Total Percentage

Chi-square table 5x4 (Table excludes "Missing" cells)
Chi-square = 12.7958
df = 12
Not Significant

merical cell entries. As an example, applying this legend to the cell in row 2, column 3, we find:

Frequency:	359
Row Percentage:	36.3
Column Percentage:	79.1
Total Percentage:	28.7

The above entries show that 359 alumni who, at the time of their entry into the UMSM, resided in Florida counties over 85,000 in population, established offices of practice in the southern states. This frequency of 359 represents 36.3% of all alumni who were residents of Florida counties over 85,000 in population. This also represents 79.1% of all alumni who were practicing in the South, i.e., of the 454 alumni whose offices of practice were established in the South, 359 had been residents of counties over 85,000 in population at the time of UMSM entry. The total percentage of 28.7% indicates that these 359 alumni represent 28.7% of the total alumni group of 1,251.

In turning to the content of Table 3, it can be noted that the cell selected for the above discussion contains the largest frequency of all identified cells, i.e., more alumni were classified by the joint occurrence of resident County Category 1 (over 85,000) and southern geographic area of practice than the joint occurrence of any other two identified levels. Additionally, the column marginal entries indicate that more alumni established offices in southern states than in any other geographic area.

This south-practicing group amounted to somewhat over 75% of the total number of private practicing alumni whose geographic area of practice was known (454 of 597), leaving relatively small numbers of alumni who had established offices in the eastern, central, and western states. Obviously, the bulk of University of Miami School of Medicine graduates who have entered private practice are in Florida and its neighboring states.

Table 4.—Distribution of Alumni by Florida Counties of Residence Upon Entry to UMSM and Later Florida County Locations of Practice.

Florida County of Residence	Missing or Not Applicable	Florida County of Practice Category 1	Category 2	Category 3	Category 4	Category 5	Row Total
Missing or Not Applicable	73 92.4 8.6 5.8	5 6.3 1.6 .4	.0 .0 ·0 .0	.0 .0 .0 .0	1 1.3 4.2 ·1	.0 .0 .0 .0	79 6.3
Category 1 Over 85,000	661 66.8 78.3 52.8	278* 28.1 87.4 22.2	19 1.9 55.9 1·5	17 1.7 68.0 1.4	14 1.4 58.3 1.1	1 .1 16.7 .1	990 79.1
Category 2 60,001 to 85,000	46 69.7 5.5 3.7	8 12.1 2.5 .6	9* 13.6 26.5 .7	.0 ·0 .0 .0	3 4.5 12.5 .2	.0 .0 .0 .0	66 5.3
Category 3 35,001 to 60,000	31 58.5 3.7 2.5	12 22.6 3.8 1.0	2 3.8 5.9 .2	7* 13.2 28.0 .6	1 1.9 4.2 .1	0 .0 ·0 .0	53 4.2
Category 4 10,001 to 35,000	22 48.9 2.6 1.8	13 28.9 4.1 1.0	3 6.7 8·8 .2	1 2.2 4.0 .1	4* 8.9 16.7 ·3	2 4.4 33.3 .2	45 3.6
Category 5 Under 10,001	11 61.1 1.3 .9	2 11.1 .6 .2	1 5.6 2.9 ·1	.0 .0 .0 .0	1 5.6 4.2 .1	3* 16.7 50.0 .2	18 1.4
Column Total	844 67.5	318 25.4	34 2.7	25 2·0	24 1.9	6 .5	1251 100.0

Legend: Frequency
Row Percentage
Column Percentage
Total Percentage

*Frequency of alumni practicing in a county in the same size category as county of residence at the time of UMSM entry.

The proportion of alumni remaining in Florida is discussed in the next section.

Florida County of Residence and Florida County of Private Practice

Data relevant to the alumni's counties of residence at UMSM entry with reference to their counties of private practice are presented in Table 4. Fully 90% of the 454 alumni shown on Table 4 who established private practices in southern states were practicing in Florida, as can be seen in the column marginal entries of Table 5. The breakdown of these 407 Florida-practicing alumni is:

1. 318 (25.4% of the total group of 1,251) in counties over 85,000 in population.
2. 34 (2.7%) in counties 60,001 to 85,000 in population.
3. 25 (2.0%) in counties 35,001 to 60,000 in population.
4. 24 (1.9%) in counties 10,001 to 35,000 in population.
5. 6 (.5%) in counties under 10,000 in population.

An interesting item of information that can be read in Table 4 is the extent to which alumni tend to practice in a county that is in the same size category as the one they resided in at the time of UMSM entry. Table 4 cells that contain these frequencies are identified by an asterisk for easy reference. Table 5 that follows is intended to clarify this point and to show the extent to which alumni established practices in counties larger or smaller than the ones in which they initially resided. It should be recognized that some information has been lost in Table 5 by categorizing counties rather than by presenting them individually; an alumnus may be practicing in a county in the same size category as the one in which he resided and yet in fact be practicing in a smaller (or larger) county. Such a situation would occur, for example, had an alumnus resided in Dade and established a practice in Broward. Both these counties are in Category 1, yet Dade is the larger of the two. One might reasonably expect fluctuations of this sort within county categories to balance out. This ambiguity occurs in Table 5 only for the frequency entries for "Practicing in Same County Category." The other column entries are clear-cut and do not contain any such error.

As can be seen in Table 5, a large majority of Florida practicing alumni (74%) establish practices in counties in the same size category as those in which they originally resided. As to category changes, a somewhat larger proportion of alumni (15%) shifted to smaller counties than shifted to larger counties (11%). This, of course, is related to the greater number of alumni originally residing in the larger counties than in the smaller ones.

Internships — Over half the alumni group (668 of 1,251) interned in southern states. Of these 668, 196 (approximately 30%) were primary care interns (excluding Obstetrics and Gynecology) and 471 (approximately 70%) were specialty care interns. Florida internships numbered 528, 79% of all internships taken in southern states. The University of Miami hospitals accounted for 358 of the Florida internships, while hospitals in counties over 85,000 in population (excluding Dade) accounted for another major group of 130 interns. Relatively few internships were taken in counties under 85,000 in population. However, it is important to note that few graduate programs are approved in areas less populated than 85,000.

The following summary ranks the geographic areas of internship and shows their frequencies and percentages of internships:

Table 5.—The Extent to Which Counties of Residence and Practice Are in the Same or Different Size Categories.

	Category Fla. County of Residence	Alumni Residing in County at UMSM Entry	Practicing From County	Practicing in Same County Category	Practicing in County Larger in Size	Practicing in County Smaller in Size
1:	Over 85,000	990	329	278	0	51
2:	60,001-85,000	66	20	9	8	3
3:	35,001-60,000	53	22	7	14	1
4:	10,001-35,000	45	23	4	17	2
5:	Under 10,001	18	7	3	4	0
6:	Unclassified	1	6			
	Total f	1,173	407	301	43	57
	Total % (f/407)			74.%	11.%	15.%

1. South: 668 (53.4%)
2. East: 237 (18.9%)
3. West: 188 (15.0%)
4. Central: 132 (10.6%)
5. Outside USA: 4 (3%)

Residencies — First year residencies were taken in 29 different medical areas. All four primary care types were represented, as were four of the ten medical subspecialties (cardiology, endocrinology and metabolism, gastroenterology, and nephrology). The most frequently occurring residency types were medicine, surgery, and psychiatry. These three medical areas represented almost a third of the total alumni group.

Data for residency type were not as complete for subsequent residency years. This is attributable to the recency of graduation of a large proportion of our 1,251 alumni and to the fact that some residency requirements are met in two or three years.

Private Practice — Slightly under half of the alumni group (609; 48.7%) had established medical practices by the time of data compilation. The geographic areas of practice were known for 599 of these 609 alumni. The distribution of these 599 practices is as follows:

South:	454 practices
West:	69 practices
East:	54 practices
Central:	20 practices
Outside USA:	2 practices

The above frequencies show clearly that the majority of practices were established in the South. Additional examination of data revealed that 407 of the 454 southern practices were located in Florida. These 407 Florida practices represent 90% of all southern practices and 67% of all the 609 practices established by UMSM alumni. To a large extent, then, UMSM alumni who have established practices have located in Florida and its neighboring states.

The distribution of the 407 Florida practicing alumni is as follows:

Counties over 85,000 in population:	318
Counties 60,001-85,000:	34
Counties 35,001-60,000:	25
Counties 10,001-35,000:	24
Counties under 10,000:	6

The 609 established practices represent 33 different medical types which distribute in the following manner:

Primary Care:	4
Specialty care:	24
Medical subspecialty:	5

Of the 609 practicing alumni, 260 (42.7%) were in primary care practices and 349 (57.3%) were in specialty care practices.

The proportion of primary care to specialty care practices for those practices established in Florida counties follows:

Counties over 85,000:
43% primary, 55% specialty (2% unknown)
60,001-85,000:
50% primary, 47% specialty (3% unknown)
35,001-60,000:
68% primary, 32% specialty
10,001-35,000:
54% primary, 46% specialty
Under 10,001:
83% primary, 17% specialty

The above precentages show that more specialty than primary care practices were established in the larger counties, while the reverse is true for the smaller counties.

Of the 597 alumni whose USA location of practice was known, 86 had been primary care interns and 509 had been specialty care interns (internship type was unknown for two alumni). There was a prevalent trend for practicing alumni to establish their practices in the South no matter where they had interned.

Summary

Although this article deals with the first phase of a comprehensive study of the activities of the alumni during the first 20 years of the School's existence, there are several important points to be emphasized. First an overwhelming percentage of alumni had Florida residence at the time they entered at the UMSM. Nearly 94% were residents of the State of Florida and this percentage has increased in the past several years. Six percent came from the rest of the United States. This demonstrates that since its founding, the UMSM has more than met its commitment to the state, and

the support formula was designed to encourage the School of Medicine in Florida. It is also very encouraging to note that over 20% of the Florida resident alumni were from counties with less than 85,000 population. This indicates that the School of Medicine has not taken students only from large counties. Many of the counties with populations between 85,000 and 100,000 were also well represented. The report further demonstrates that 74% of the alumni with Florida residence who have entered private practice have established their practice in a county comparable as to size category as the ones from which they came. Finally it is important to note that of the 609 practicing alumni, 42% are primary care physicians and 58% have specialty care practices. This figure would even be higher if the traditional categorical inclusion of obstetrics and gynecology had been made for primary care physicians at the beginning of this study.

These data and those obtained subsequently indicate that a substantial proportion of the UMSM's alumni are practicing in Florida, and that over 40% are in the category of primary care physicians. Considering the fact that nearly 60% of the housestaff at Jackson Memorial Hospital are in primary care postgraduate training programs, it is clear that the State of Florida's initial investment has paid substantial dividends and significantly improved the quality of medical care offered in the state.

▸ Dr. Robinson, Associate Dean for Student Affairs, University of Miami School of Medicine, P. O. Box 520875, Biscayne Annex, Miami 33152.

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—Edwin Markham

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SPECIAL ARTICLES

Commencement Address

E. M. Papper, M.D.

Mr. President, Members of the Board of Trustees, Honored Guests, Members of the Faculty, Parents, Spouses, and the most recent additions to our ancient and noble profession, the graduates of the University of Miami School of Medicine, the Class of 1976.

This is a year of celebration, a year of anniversary, a year of multiple reasons for looking forward in the light of what happened in the past.

Let me mention some events and how they relate to you. This is the 200th anniversary of the birth of the United States of America. It is the 50th anniversary of the University of Miami. 1976 marks the 20th anniversary of the School of Medicine's first graduating class.

It is an occasion presided over by a youthful distinguished President, who by the authority vested in him, has conferred the degree of Doctor of Medicine on 1,374 or 80% of all the graduates of our School of Medicine since the establishment of the school.

In thinking about an appropriate message that could be brought to your attention during these happy yet solemn moments, it occurred to me to look back, in the spirit of also looking forward, to a document of vast importance to all of us, The Declaration of Independence. It is also a special document for physicians in addition to its importance to the country.

It is not well known that there were 56 signers of this Declaration and that five of these were physicians. Three of the nonphysicians also wrote widely upon medical subjects and were highly respected in medical circles.

One of them was Benjamin Franklin, who among other medical acts studied the use of electricity for nervous disorders, invented the bifocal lense and the flexible catheter. He was a member of the medical societies of London, Paris and Edinburgh. The other nonphysician person highly thought of in connection with medicine was John Witherspoon, who was a clergyman and president of what was then the College of New Jersey which is now Princeton University. Although not a physician he too encouraged much activity in medicine and was one of the first to advocate a school devoted to medical studies at the College of New Jersey, a goal which Princeton has not as yet achieved, even in 1976.

Thomas Jefferson, the author of the Declaration and a nonphysician, wrote extensively about medicine, child care and social welfare. He believed that medical science is "the most important of all others," the study of anatomy particularly valuable and that "no knowledge can be more satisfactory than that of its own frame, its parts, their functions and actions." Of this intellectual giant, John F. Kennedy said, when he, as president, had a dinner at the White House for all living American Nobel Laureates: "Never has the White House been graced by so much intelligence except when Thomas Jefferson dined alone."

One might ask why five physicians signed the Declaration—a number greatly in excess of their proportionate numbers in the general population. Why did they go to Philadelphia in 1776? The answers to these questions are still incomplete, but some features stand out. Physicians in Colonial America sorely needed to achieve a recognized social status and economic betterment which was reflected in their participation in the process of government. The poor remuneration of most physicians could have been a reason why so many eagerly accepted public office and military commissions with

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Delivered before the 1976 graduating class from the University of Miami School of Medicine, June 6, 1976.

a known cash revenue and regular salaries to supplement their unreliable source of income from the practice of medicine. Economics was not the only reason, however, prestige was another. The practice of medicine in Colonial America did not rank with the law or ministry in the intellectual endowments it required and therefore in the social rank it conferred, however, physicians were often the scientists of their day in a period of precious little scientific information and study. Physicians, in addition to being the scientists of Colonial America, were also part of the rising middle class and they believed that a just society would be the outcome of the application of scientific precepts—a central theme of the enlightened thinking of the 18th century. It was a period in which the age of revolution would, in due time, eliminate injustice, tyranny, and undeserved privilege from human society. This ferment of activity was associated among other things with the founding of the first medical schools and permanent medical societies in Colonial America. It was widely believed that the doctrines of Bacon, advocating the utility of science and its application for the betterment of man, was essential. The American environment strongly reinforced this idea, then and now by providing significant support for scientific projects only when a clear utilitarian gain for the people seems likely. The separation from England only intensified this feeling. These five out of 56 were Josiah Bartlett and Matthew Thornton of New Hampshire, Oliver Wolcott of Connecticut, Lyman Hall of Georgia, and Benjamin Rush of Pennsylvania.

The participation of these physicians in the establishment of their country certainly rescued medicine from its former almost slavish rank in society. These physicians, as well as others, were also demonstrating what they could do as patriotic men of affairs. They were natural leaders of the community, freer than the clergy of those days to accept public service. It was the beginnings of the establishment in the minds of the people of a popular and respectful esteem for the medical profession. Benjamin Rush always urged his students to have regard for the interests of their country, to be sure to diffuse knowledge to all the people about science and medicine. He also felt strongly that they should lead and speak out on public questions.

The attitude of these physicians was remarkable in many ways. Benjamin Rush, whose likeness is embossed on the official seal of the American Psychiatric Association and who is considered the founder of American Psychiatry, believed that for every ill and illness there was an appointed remedy. He set out to overcome nature as well as human nature in the conquest of disease. Armed with his lances, pills and purges he confidently led the assault upon what he liked to call the temple of the human body which he believed must inevitably yield like the body politic to benevolent and determined action. Dr. Rush believed that the United States would become a great, free, happy commonwealth in which men, women and children of all races would be brothers and sisters, in which war and pestilence would be known no more and the bright promises of the American Revolution would be well fulfilled in the context of providing more health for more people.

There are some amusing notes in this connection. Colonial and European medicine were very limited in the 18th century. While some surgery was performed, anesthesia was unknown. Some drugs were available, but their action poorly understood and their active principles unpredictable in amounts. Rush, in his enthusiasm, purged and bled for all illnesses. He believed all diseases were due to spasm of the blood vessels. Diarrhea and hemorrhage added to the problems of disease in the hands of this most distinguished of physicans of his day—very energetic—but limited by the knowledge of his times.

The lack of skill of colonial surgery also lost New York to the British. George Washington had a carbuncle on his buttock as the British fleet and regular troops began the battle for New York. He was purged and bled and the carbuncle remained. He could not mount his horse because of the pain of the infection and the weakness from his therapy —and so New York was lost as the Commander could not command.

Several of the signers of the Declaration went to Yale where they did not study medicine, but Liberal Arts as they were known at that time. Yale was an institution in those days, as noted by Roland Bainton, that was "conservative before she was born." All of them were apprenticed, as was the custom of the 18th century, to practicing physicians to learn medicine. The preceptor idea as the medical people in this audience know, is not new. The physicians of The Declaration of Independence were not much different from the Continental Congress in personality and style. They were a strange and contradictory blend of Yankee industry and impatience and of Southern aristocratic self confidence and middle colony caution and circumstance. Some of our physician signers of The Declaration of Independence were hard working average men. For example,

Oliver Wolcott, it was said, sustained rather than created and supported rather than led; however, he pledged his life, his fortune and his honor in defense of his belief; not much more can be said of anybody. Of Matthew Thornton it was said that he signed The Declaration of Independence largely by chance. Despite this happenstance, and the fact that he learned the practice of medicine from two English surgeons who were outlawed as pirates and who lived with his father for seven years, Dr. Thornton made a major contribution to public affairs and was a reliable practitioner of medicine. He made an important advance in the state of medical practice by open mindedness. He was among the first to use the New Hampshire Indian remedies which were considerably more effective or at least less harmful than the purges and bleeding so common among the colonial physicians of the time. One of them, Josiah Bartlett, established the first Medical Society in the United States. The southerner Lyman Hall was actually a transplant from Connecticut. He and two of his colleagues apparently succeeded in eliminating from The Declaration of Independence the draft prepared by Thomas Jefferson that condemned George III for continuing the foreign slave trade. The fantastic genius among the five was Benjamin Rush. This incredible man of many accomplishments was of a stature akin to that of Benjamin Franklin. He did much for medicine, in Colonial America and in the young United States of America. He founded the first medical school in the country, the Medical College of Philadelphia currently the School of Medicine of the University of Pennsylvania. His influence upon political affairs and independence was that of a classic 18th century intellectual genius in which medicine was among one of many of his massive accomplishments. His views of education are significantly those of the Jeffersonian enlightenment. He believed that the great design of education was to prepare youth for usefulness here and for happiness hereafter. He thought that fixed and traditional courses should be avoided, and advocated a course in "The Art of Forgetting" for all who influenced public opinion.

I should like to leave with you the thought in a prayer of Maimonides. "I pray that God would inspire us with love for his creatures. The thirst for profit, the ambition for renown, and for admiration must not interfere with this profession. Preserve the strength of my body and soul that they may ever be ready to help rich and poor, good and bad, enemy and friend. In the sufferer let me see only the human being."

▶ Dr. Papper, University of Miami School of Medicine, Miami 33156.

Education is a social process. . . .
Education is growth. . . .
Education is not preparation for life;
Education is life itself.

John Dewey

Research Grants for 1976-1977 Accepted Until October 30th. The Florida Medical Foundation Committee on Research will accept applications for 1976-1977 research grants until October 30th. Applications and other information may be obtained by contacting J. Lee Dockery, M.D., Chairman, Committee on Research, Florida Medical Foundation, P. O. Box 2411, Jacksonville 32203. Recipients will be announced early in 1977.

Hospital Contingency Plan for "Swine-Flu" Epidemic

The Infection Control Committee of Halifax Hospital Medical Center, Daytona Beach, Florida has been monitoring State Communicable Disease Reports, MMWR from CDC and other communications concerning the likelihood of a "Swine-Flu" epidemic this fall and winter. The hospital is located in a community which has a large permanent retired population and which experiences a large influx of tourists and seasonal visitors each fall and winter. While admissions routinely peak with large numbers of patients exhibiting a variety of health problems during these months the Committee members felt a plan was needed in the event of an epidemic which may double or triple admissions of influenza and flu-like illnesses. Certain questions were considered in devising such a plan. What are the symptoms of A/New Jersey/76 (so called Swine-Flu)? Do the patients require isolation? What kind of isolation? In response to the identified needs inquiries were made to the local Public Health Department and to CDC in Atlanta. Some answers to the questions included information that the symptoms of A/New Jersey/76 are the usual symptoms of influenza; fever, myalgia and headache with the complication of severe upper and lower respiratory symptoms. The death at Ft. Dix was due to viral pneumonia. Isolation of susceptible individuals from acutely ill patients is recommended.

It was decided to develop a contingency plan to be implemented in the event of an epidemic. New questions were raised which needed answers before the actual plan could be dealt with. What is the criteria for diagnosis? What is the magic number of admissions with flu for initiating the plan? Will all flu patients be admitted to one unit? What about visitors? Should a hospital-wide vaccination plan include physicians and volunteers? The following was developed as answers were found to the questions. The contingency plan itself came about naturally after formulation of the questions and answers. The diagnosis and determination of isolation will be the responsibility of the individual physicians.

The Nurse Epidemiologist will be aware of the admissions with a diagnosis of influenza or flu-like symptoms. She will keep the chairman of the Infection Control Committee and the Nursing Director appraised of the numbers. When the number of admissions with influenza for one day has reached ten, they will consult with the Chief of Staff and Hospital Administrator regarding implementation of the contingency plan. The plan includes:

(1) A medical unit will be designated from that date to admit only those patients with the diagnosis of influenza. There will be another medical floor designated for overflow. It may be necessary to transfer patients off the floor to other units in order to provide beds for the influenza patients. This plan was determined to be superior to opening a previously closed unit in order to minimize staffing problems. In the event of an epidemic there will be employees out sick.

(2) A hospital-wide program will provide vaccination of all employees, physicians and auxiliary who work in patient care areas.

(3) Consideration of restricting elective admissions may be undertaken if indicated.

(4) Separation of patients with influenza and other patients is recommended in the Admitting area and Emergency Department.

(5) Visitors will be limited to one per patient on all hospital units. Visitors with flu-like symptoms will not be allowed in patient care areas. No visitors will be permitted to use the cafeteria in order to reduce the workload in the event of a reduced number of kitchen workers. An appeal to the community concerning the visiting policy can be initiated through the Public Relations Department.

This is the basic plan the Infection Control Committee adopted. The specific details remain to be worked out. Halifax Hospital Medical Center is a large 500-bed community hospital. This plan may be helpful in starting a dialogue or becoming the basis for other institutions, with variations, depending upon individual needs and situations.

Pat Robertson, R.N.
Epidemiologist
William P. Douglass, M.D.
Chairman, Infection Control Committee
Halifax Hospital Medical Center
Daytona Beach

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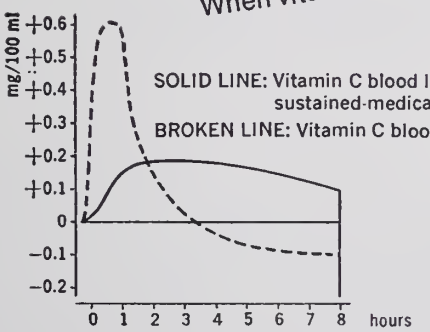
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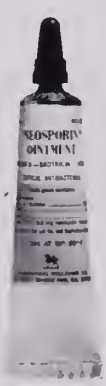
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ORGANIZATION

Report on National Rural Health Conference

R. Edward Dodge, M.D.

The 29th National Rural Health Conference held in Phoenix this year provided new food for thought about rural health. It also addressed the usual catalog of rural health service problems such as maldistribution of physicians, transportation, communication and financial, all of which appear more accentuated in rural areas.

M. Roy Schwarz, M.D., of Seattle, Associate Dean of the University of Washington School of Medicine, presented the opening address. Most startling, perhaps, was his prediction that within the next five or ten years there will be too many trained health practitioners including middle level practitioners such as the nurse practitioner and physician assistant. The result, Dr. Schwarz said, was that the stage would be set for serious interprofessional conflicts. He emphasized that quality of care is an increasingly important issue but one difficult to handle because of lack of definition of accepted endpoints in quality.

Another speaker, Charles E. Lewis, M.D., of Los Angeles, Professor and Head of the Division of Ambulatory and Community Medicine at U.C.L.A. School of Medicine, discussed quality of care in connection with "Inter-Community Health Service Networks" which he said was just a fancy phrase for the concept of regionalization. Dr. Lewis stated that intermediate level practitioners have been shown to work very well and to provide excellent quality of care within a well organized health care system. Responding to a question, however, he replied that the market could well become "soft" for intermediate level practitioners within five to ten years because of factors discussed by Dr. Schwarz.

Dr. Lewis did not paint a utopian picture about regionalization. He pointed out that regionalized systems of care are not likely to work well on a grand scale in the United States. He said they will work on a limited, cooperative basis and are the only feasible way of developing adequate systems of care.

Anne R. Somers of New Brunswick, N. J., Professor in the Department of Community Medicine at Rutgers Medical School, speaking on educating the consumer, declared that behavior adverse to health is the top health problem in the United States. She acknowledged that changing such behavior is not easy but cited impressive studies to show that health education can influence peoples' behavior significantly.

Theodore Cooper, M.D., of Washington, Assistant Secretary for Health in the Department of Health, Education, and Welfare, outlined a federal program to stimulate development of local resources without tying up federal money in ongoing local programs over long periods of time. He emphasized that cost containment is an extremely important health policy problem to which the federal government will give more and more attention.

There were other speakers and many workshops in addition to these addresses. Overall the conference was worthwhile. It seems apparent that organized systems of health care and the problem of cost containment are topics which will be receiving much attention at the national level in the near and middle future.

▶ Dr. Dodge, 204 North Trout Street, Inverness 32650.

Dr. Dodge is Chairman of the Committee on Rural Health of the Florida Medical Association.

Volusia County Physician Ministers to Speedway Injured



Dr. A. A. Monaco of Ormond Beach, Chief of the Daytona International Speedway's medical staff, receives from Mr. William Simpson an award for the staff's service during the NASCAR Grand National races last summer. Others in picture are nurses Delores Blanyer and Kathryn Johnson, and Dr. C. V. Herron, Assistant Medical Director.

On a non-race day, the sprawling Daytona International Speedway beside busy U.S. 92 at Daytona Beach appears deserted except for custodians and other fulltime staff. Its vast parking lots and grandstands are virtually empty.

Then, the day of a big auto race. Spectators by the tens of thousands suddenly fill the emptiness.

That's when Achille Anthony Monaco, M.D., of Ormond Beach, really goes to work. He heads a large crew of physicians and nurses who are prepared to cope with virtually any medical emergency or non-emergency.

The track boasts its own hospital, which Dr. Monaco believes is one of the finest facilities of its kind in the sports world.

"When you stop to consider that what we have here during a big race is a crowd equivalent to a city of 100,000 people, we need to have an emergency medical facility to accommodate it," he explains.

Dr. Monaco established the emergency center at the track 18 years ago, but due to more races and larger crowds, more space is needed.

"We've outgrown this building, so we're starting work now on a facility with increased bed space, private examining and observation rooms and an emergency room with the latest equipment available to handle the increased load," he relates.

There will be a new therapy room with huge ice tanks and shower stalls to handle burn cases, a common type of accident at the track.

With a network of first aid stations manned by doctors and nurses spread over the track area, the track hospital on the premises and the Halifax Medical Center just down the highway, Dr. Monaco's team is able to handle about any situation.

NASCAR drivers Buck Baker and Cecil Gordon can attest to the track's medical capabilities. Both were taken to the track hospital after an accident during the Firecracker 400 the last July 4 holiday weekend. Both were examined and treated at the track hospital, then taken to Halifax for further observation.

But race car pileups by no means occupy all the staffs' time. They have seen mechanics with finger lacerations, spectators on the verge of collapse due to heat, and track officials with sprained ankles, among many others. Once in a while one of Dr. Monaco's team even is called upon to preside at childbirth.

Race track medicine is not Dr. Monaco's only interest in sports medicine. He has been attending physician for many high school athletic teams in his area and has worked with the Pittsburgh Pirates and Kansas City A's farm clubs when they were based in Daytona Beach in the 1960s. For the past five years he has helped look after the Montreal Expos in spring training.

How does he like this unique type of medical practice?

"Sports medicine is a practice in itself," he replies, pointing out that residents from Halifax do stints at the track as part of their graduate study.

A native of Pennsylvania and a graduate of the old Middlesex University School of Medicine in Massachusetts, Dr. Monaco has been an active participant in the affairs of organized medicine. A member of the Florida Medical Association, he has held all major offices in the Volusia County Medical Society and several years ago was vice president of the Florida Academy of Family Physicians.

Life in the twentieth century is like a parachute jump; you have to get it right the first time.

Margaret Mead



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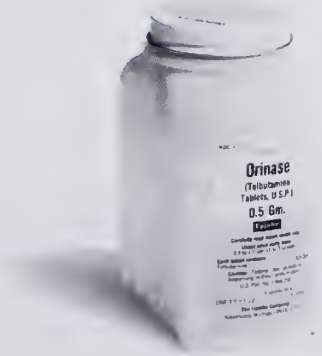
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Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

The Patchwork Mouse by Joseph Hixson. 228 Pages. Price $7.95. Anchor Press/Doubleday, Garden City, New York, 1976.

Joseph Hixson has done an excellent job presenting the tensions, the problems, and perhaps, the errors that occur when research is made big business and large sums of money are involved. He has used the case of Doctor William Summerlin to present in an extremely readable form what can happen in a research atmosphere charged with the pressure to produce and funded by large sums of money. The name of the game is frequently "grantsmanship" to obtain continued support with funds, Government and otherwise, to produce tangible results in a short period of time.

Doctor William Summerlin, a dermatologist by training, but engaged in research reported in 1973 that he had succeeded in transplanting skin from a black mouse to a white mouse of a different species. The fact that they were later found to be genetically related proved an important factor in his subsequent difficulty at the Sloane-Kettering Institute. In 1974, he blackened the skin of white mice to show to his superior, Doctor Robert Good. This was done with a felt pen. Doctor Good apparently paid little attention to the mice. This was later discovered by an animal caretaker and brought to the attention of other doctors, which precipitated an investigation of Doctor Summerlin's work and his later dismissal from the Sloane-Kettering Institute.

Joseph Hixson uses this as a means of discussing and showing the problems of research, the pressures put on investigators in an attempt to secure grant money and to obtain the acclaim of the public, the science writers and peer prestige. The author points out that during 1974, the expenditures at Sloane-Kettering jumped from an anticipated level of just under $18 million to over $21 million. The fact that the budget was over that estimated, did not seem to bother people as much as the pressure and the scramble to obtain more money from grants.

I suspect that much of this reflected the thinking in Washington, that if you spend enough money, you could produce anything, even a cure for cancer. I would suppose that some of this was influenced by the amount of money spent on the Viet Nam War and on the space program. It is unfortunate that this type of thinking apparently also influenced quite a number of scientists or at least people in administrative positions. The fact that a cure for cancer has not come about with these large sums of money, of course is now history.

Mr. Hixson also has used this book to bring forth the part played by the media in influencing research, although perhaps, not intentionally. Reporters, whether they be in newspaper or television, are looking for an impact that will strike the public's eye, and obtain the largest amount of readers. Responsibility is no doubt a consideration of many of the science writers and many do check their reports carefully before they are published; this does not seem, by any means, to be their greatest consideration. The desire to publish something as a "breakthrough" seems to be more important than the responsibility of reporting, checking and assuring the accuracy of reports before they are foisted on the reading public or the viewing television audience. Not all of this type of reporting is due to the reporting media. A part of it must be laid to rest at the doors of those scientists who, in seeking publicity, do so for reasons of increasing their prestige and, thereby, their ability to obtain public grant support.

This book should be read by every young physician interested in a career in research; it is of interest to all practicing physicians, many of whom are only vaguely aware of the pressures in the research community. It should have a sobering influence on those actively engaged in research. The young scientist interested in a career in research should not look to this as a description of the way research should be done. Rather he should look to some of the giants of the past in their search for truth—namely Robert Koch, Louis Pasteur, and in more recent times, Frederick Banting. Money does not solve all problems; as a matter of fact, it frequently creates more than it solves.

A. Lee Messer, M.D.
St. Petersburg

Dr. Messer is a pacticing cardiologist in St. Petersburg.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Food For People, Second Revised Edition, by Sarah R. Riedman. 228 Pages. Illustrated by Robert McGlynn. Introduction by Lord John Boyd Orr. Price $6.95. New York, Abelard-Schuman, 1976.

The Human Heart—A Guide to Heart Disease by Brendan Phibbs, M.D., F.A.C.P., F.A.C.C., 2nd edition. 247 Pages. Price $5.75. 102 Illustrations. The C. V. Mosby Company, St. Louis, 1971.

Plagues and Peoples by William H. McNeil. 369 Pages. Price $10.00. New York, Doubleday & Company, Inc., 1976.

Solved: The Riddle of Heart Attacks by Broda O. Barnes, M.D., Ph.D. and Charlotte W. Barnes, A.M. 84 Pages. Price $2.50. Fort Collins, Colorado, Robinson Press, Inc., 1976.

Review of Medical Pharmacology, 5th Edition by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D. and Alan Goldfien, M.D. 740 Pages. Illustrated. Price $12.50. Los Altos, California, Lange Medical Publications, 1976.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

Contact Lenses and Corneal Disease by Antonio R. Gasset, M.D. 403 Pages. Illustrated. Price $22.50. New York, Appleton-Century-Crofts, 1976.

The Woman Alcoholic by Vera Lindbeck. 28 Pages. Price 35¢. New York, Public Affairs Pamphlets, 1975.

Principles of Clinical Electrocardiography, 9th Edition by Mervin J. Goldman, M.D. 412 Pages. Illustrated. Price $9.95. Los Altos, California, Lange Medical Publications, 1976.

Review of Medical Microbiology, 12th Edition, by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. 542 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price $15.00. Los Altos, California, Lange Medical Publications, 1976.

So Get On With It by Marilee Weisman & Jan Godfrey. 159 Pages. Illustrated. Price $8.95. Garden City, New York, Doubleday & Company, Inc., 1976.

Preparation for Parenthood Through Group Discussion by Aline B. Auerbach. 57 pages. Available on request from Educational Services, Patient Care Division, Johnson & Johnson, New Brunswick, N. J. 08903.

This book by a parent group consultant is subtitled, "A Guide For Nurse-Leader of Expectant-Parent Classes". This guide includes chapters on organization of expectant parent discussion groups, basic requirements for leadership, as well as techniques of group discussion and suggested curriculum. It includes a bibliography for suggested reading.

INFORMATION FOR AUTHORS

Manuscripts should be submitted to the Editor of the Journal, Florida Medical Association, P. O. Box 2411, Jacksonville, Florida 32203, in original and one duplicate copy. Copy should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of the Journal and may not be published elsewhere without permission from the author and the Journal.

Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

Synopsis-Abstract. All manuscripts should include a 150 word, maximum length, synopsis-abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes your article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work was done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to **Index Medicus,** volume number, page numbers and year of publication. All references must be cited in text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, we reserve the right to eliminate with notation: References are available from the author(s) upon request.

All accepted manuscripts are subject to copy edlting. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase understanding of text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed, double-spaced on separate sheet of paper. The following information should be typed on an adhesive strip and affixed to back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self-explanatory and should supplement, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

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SPEAKERS

INTERNAL MEDICINE
Raymond Gifford, M.D.
Cleveland Clinic

NEUROLOGY
Herbert Karp, M.D.
Emory University
Clark H. Millikan, M.D.
Mayo Clinic
Robert G. Siekert, M.D.
Mayo Clinic
James Toole, M.D.
Bowman Gray School of Medicine

PEDIATRICS
Manuel Gomez, M.D.
Mayo Clinic

NEUROVASCULAR SURGERY
Robert G. Ojemann, M.D.
Massachusetts General Hospital
O. Howard Reichmann, M.D.
Loyola Univ. Medical Center
James T. Robertson, M.D.
University of Tennessee
Jesse E. Thompson, M.D.
Dallas, Texas
M. Gazi Yasargil, M.D.
Kantonspittal, Zurich, Switzerland

NEURORADIOLOGY
Juan M. Taveras, M.D.
Massachusetts General Hospital

PHYSICAL MEDICINE
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Dianne C. H. Bader, R.N.
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Mr. Ronald A. Nelson
Executive Director
American Heart Association
Broward County Chapter
440 North Andrews Avenue
Fort Lauderdale, Florida 33301

REGISTRATION CLOSES FEBRUARY 4, 1977.



University of Miami School of Medicine . . . and Jackson Memorial Medical Center are assembling a cadre of first rank specialists to staff their new Institute of Kidney Diseases.



Functioning under the direction of noted nephrologist **Neal S. Bricker, M.D.,** the Institute will wage an inter-disciplinary attack on the causes of kidney diseases and prevention of their damaging effects. Formerly Professor and Chairman of the Department of Medicine at Albert Einstein College of Medicine in New York, Dr. Bricker recently joined the Miami faculty as Professor of Medicine and Vice Chairman of the Department.

A group of kidney specialists already has joined Dr. Bricker, and other outstanding scholars with research and clinical backgrounds will become members of the team.

In the past 20 years Dr. Bricker and his associates have made major contributions to the studies of renal failure. The framework they developed for the understanding of the pathophysiology of chronic renal failure has become a fundamental part of contemporary teaching in nephrology.

Dr. Bricker was the first President of the American Society of Nephrology and is a Past President of the American Society for Clinical Investigation. His many other appointments have included the chairmanship of the National Kidney Foundation and the Kidney Disease Committee of the National Institute of Health.

Donn L. Smith, M.D. . . . has resigned as Dean of the College of Medicine and Director of the Medical Center at the University of South Florida, Tampa, effective September 15. He will remain on the faculty as Professor of Medicine and Physiology.

"The initial objectives for the medical center and the college of medicine which were promulgated in 1970 have been met and I believe my contribution has been made," Dr. Smith said in his letter of resignation to USF President Cecil Mackey. "It is my sincere professional opinion that the complex and arduous administrative functions related to modern medical education operations require periodical and timely changes of leadership."

Dr. Mackey praised Dr. Smith for his dedication and accomplishments in recruiting a faculty and guiding Florida's youngest medical school through its early years.

Dr. Smith, 61, arrived in Tampa in 1970 to take charge of the fledgling medical school. He had previously served as Assistant Dean at the University of Colorado and as Dean at the University of Louisville.

A native of Denver, Colo., Dr. Smith was awarded the M.D. degree in 1958 at the University of Colorado after earning A.B., M.S., and Ph.D. degrees.

No successor in the University of South Florida administrative position has been named.

James L. Talbert, M.D. . . . Professor and Chief of Pediatric Surgery at the University of Florida College of Medicine, has been elected to membership in the British Association of Pediatric Surgeons.

Dr. Talbert, the first Florida physician to be named to the Society, was elected at the group's 23rd Annual International Congress in Sheffield, England, where he presented a paper.

The Greater Miami Radiological Society . . . has elected **David C. Hillman, M.D.,** of North Miami as its new President.

Other new officers are: **Kenneth D. Keusch, M.D.,** Miami, Secretary; **Joel A. Schneider, M.D.,** Miami, Vice President; and **Philip Gassman, M.D.,** Miami, Treasurer.

University of Florida Health Center . . . is expanding its cancer treatment and research program

through a reorganization of the Division of Hematology and Oncology.

A separate Division of Oncology has been created with **Roy Samuel Weiner, M.D.,** most recently of the Harvard University faculty, as Chief. Known for his studies of bone marrow transplantation, he arrived in Gainesville in August to assume his new duties and begin recruiting additional faculty for his staff.

"The new division will greatly strengthen both patient care and educational programs in this important area," according to Dean Chandler A. Stetson, M.D.

Ward D. Noyes, M.D., continues as Professor and Chief of the Division of Hematology.

Cedars of Lebanon Health Care Center in Miami . . . has won provisional approval of its educational program from the FMA Committee on Continuing Medical Education.

The accreditation will be effective for one year from August 3, 1976, and is subject to concurrence of the American Medical Association. Accreditation means that Cedars may designate which of its CME programs offer AMA Category 1 credit.

The Cedars program is the fourth to be accredited since the AMA approved the state committee's accreditation program more than two years ago. Previously accredited were Halifax Medical Center in Daytona Beach, Sarasota County Medical Society, and South Florida Psychiatric Society.

The Escambia County Medical Society . . . will present a Seminar on Public Relations, November 12th, in Pensacola. This is designed for the physician and his staff. Ms. Karen Zupko from the AMA will present a workshop on managing the telephone and the approaches to medical collections.

In addition, a panel will discuss how to avoid medical malpractice. For details write the Escambia County Medical Society, 2201 North 9th Avenue, Pensacola 32503.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

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Deaths

Brown, Robert J., Jacksonville; born 1920; University of Georgia, 1944; member AMA; died May 26, 1976.

Cannon, Curtis W., West Palm Beach; born 1926; University of Miami, 1956; member AMA; died June 10, 1976.

Claytor, Samuel B., Tampa; born 1927; Medical College of South Carolina, 1956; member AMA; died May 21, 1976.

Des Jean, Paul A., Pompano Beach; born 1906; University of Indiana, 1942; member AMA; died February 21, 1976.

Fernandez, Jose M., Miami; born 1935; University of Madrid-Spain, 1969; member AMA; died March 27, 1976.

Ferrara, John D., Orange Park; born 1906; Yale University, 1932; member AMA; died July 20, 1976.

Goethals, Paul L., Winter Park; born 1933; Stritch (Loyola University), 1958; member AMA; died May 6, 1976.

Lanier, William T., Coral Gables; born 1890; University of Georgia, 1912; member AMA; died May 7, 1976.

Luce, Henry A., Naples; born 1910; Georgetown Medical School, 1936; member AMA; died May 15, 1976.

Machle, Sr., Willard, Coral Gables; born 1901; University of Cincinnati, 1925; member AMA; died April 30, 1976.

Mahrer, Martin P., Miami; born 1893; Royal Hungarian University of Budapest, 1915; member AMA; died April 18, 1976.

Mason, William G., Clearwater; born 1907; Tulane University, 1941; member AMA; died April 12, 1976.

Maxwell, Roscoe S., Punta Gorda; born 1922; Washington University, 1925; died June 23, 1976.

McConnell, Whitman C., St. Petersburg; born 1893; University of Pennsylvania, 1917; member AMA; died June 13, 1976.

Melich, Edward I., St. Petersburg; born 1906; George Washington University, 1932; member AMA; died May 21, 1976.

Milam, Ernest B., Jacksonville; born 1888; Vanderbilt University, 1919; member AMA; died June 8, 1976.

Nadel, Morris, West Palm Beach; born 1906; Columbia University, 1927; member AMA; died March 16, 1976.

Peterson, Claus A., Fort Lauderdale; born 1888; University of Vermont, 1912; member AMA; died October 18, 1975.

Raulerson, Hiram H., Jr., Okeechobee; born 1931; University of Miami, 1960; member AMA; died March 6, 1976.

Rowe, Alvah L., Lake Worth; born 1899; Emory University, 1924; member AMA; died February 11, 1976.

Rumball, John M., St. Petersburg; born 1909; University of Minnesota, 1934; member AMA; died April 16, 1976.

Scala, Raymond D., Winter Park; born 1928; Bowman Gray College of Medicine, 1954; member AMA; died July 1, 1976.

Sisk, Wilfred N., Orlando; born 1911; University of Wisconsin, 1935; member AMA; died March 21, 1976.

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S-2.	6	60	____			
S-3.	6	60	____			
S-4.	6	60	____			
S-5.	3	30	____			
S-6.	3	30	____			
S-7.	5	50	____			
S-8.	3	30	____			
S-9.	3	30	____			
S-10	3	30	____			
S-11.	11	130	_____			
S-12.	6	60	_____			
S-13.	6	60	_____			
S-14.	6	60	_____			
S-15.	6	60	_____			
S-16.	6	60	_____			
S-17.	3	30		____		
S-18.	3	30		____		
S-19.	3	30		____		
S-20.	3	30		____		
S-21.	3	30		____		
S-22.	3	30		____		
S-23.	12	120		____	_____	
S-24.	6	60		_____		
S-25.	6	60		_____		
S-26.	3	30			____	
S-27.	3	30			____	
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S-29.	3	30			____	
S-30.	3	30			____	
S-31.	3	30			____	
S-32.	6	60			_____	
S-33.	6	60			_____	
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Special Note • In addition to the postgraduate courses outlined here, the Oct. 11, 1976, **JAMA** Convention Issue contains 9 general sessions, 16 luncheon sessions, and 32 "Meet the Professor" meetings available to you. The AMA's Philadelphia Clinical Convention Brochure also contains this information. All inquiries should be directed to the **AMA Department of Meeting Services, 535 N. Dearborn St., Chicago, IL 60610** and/or direct phone inquiries to: **AMA Department of Meeting Services at (312) 751-6187.**

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The Bicentennial City • It is particularly appropriate in this Bicentennial Year that Philadelphia be the site of AMA's 30th Clinical Convention. Because Philadelphia is not only the birthplace of our Nation, but it can also lay legitimate claim to being the cradle of American medicine. It is the site of the first hospital, the first medical school, and the home of many famous American Colonial physicians, such as Benjamin Rush, John Shippen, and John Morgan.

In your off hours, you can step back into history with visits to Independence Hall, the new Liberty Bell Pavilion, Betsy Ross' House, the Franklin Institute, and many other historical sites. For all of its historical significance, Philadelphia is as modern and sophisticated a city as there is. There's a multitude of superb restaurants to delight the gourmet, including the Old Original Bookbinder's.

Plan Now for Your CME in Philadelphia • Use the coupon to register now for the postgraduate courses of your choice. The complete selection and full descriptions of the over 103 CME events will be available in the October 11, 1976, Clinical Convention Issue of the **Journal of the American Medical Association (JAMA).** You may also check the coupon box to receive the AMA's Philadelphia Clinical Convention Brochure which has material similar to the **JAMA** Convention Issue. After filling in information, send this coupon to the AMA with your accompanying check or money order. Advance registration requests must be received by October 29, 1976. Course tickets and registration materials will be sent to you on November 12, 1976. All tickets requested after that deadline date will be held for pickup at the Postgraduate Registration Desk in the Philadelphia Civic Center.

If the minimum course registration is not attained for your first choice, or if the course is full, one of your alternate choices will be substituted. It is best to register early because the class sizes are limited. All medical students, interns, and residents are entitled to a 50% discount on postgraduate course fees ($10 per Category 1 credit hour is standard rate).

Postgraduate Courses

Saturday, Dec. 4, 1976

7:30 AM-Noon (5 hours: $50)
- *S-1. Basic Life Support (Cardiopulmonary Resuscitation—CPR)

9:00 AM-5:30 PM (6 hours: $60)
- S-2. Practice Management Seminar
- S-3. Writing for Scientific Journals
- *S-4. Nutrition: Parenteral & Alimentary

9:00 AM-Noon (3 hours: $30 each)
- *S-5. Basic Electrocardiography
- S-6. Evaluation of the Dizzy Patient

1:00-5:30 PM (5 hours: $50)
- S-7. Basic Life Support (CPR)

2:30-5:30 PM (3 hours: $30 each)
- S-8. Hematologic Disorders in Children
- S-9. The Eye & Office Practice
- S-10. Coronary Artery Disease: Medical vs Surgical Therapy

Sat., Dec. 4 & Sun., Dec. 5

9:00 AM-5:30 PM & 9:00 AM-Noon (11 hours: $110, plus $20 lab fee = $130)
- S-11. Public Speaking Seminar

9:00 AM-Noon & 9:00 AM-Noon (6 hours: $60 each)
- *S-12. Fluid & Electrolyte Therapy
- S-13. Diseases of the Bowel
- S-14. Arthritis Update: Medical & Surgical Management

2:30-5:30 PM & 2:30-5:30 PM (6 hours: $60 each)
- *S-15. Management of Diabetes Mellitus
- S-16. Hypertension

Sunday, Dec. 5, 1976

9:00 AM-Noon (3 hours: $30 each)
- S-17. Diagnosis & Treatment of Fractures of the Upper Extremities
- *S-18. Advanced Electrocardiography
- S-19. Emergency Medicine

2:30-5:30 PM (3 hours: $30 each)
- *S-20. Pulmonary Function & Blood Gases
- S-21. Behavioral Problems Involving Children & Adolescents
- S-22. Recent Advances in Cancer Surgery

Sun., Dec. 5 & Mon., Dec. 6

7:30 AM-5:30 PM & 7:30 AM-Noon (12 hours: $120)
- S-23. Advanced Life Support (CPR)

9:00 AM-Noon & 9:00 AM-Noon (6 hours: $60)
- S-24. Jaundice: Diagnosis, Treatment & Management

2:30-5:30 PM & 9:00 AM-Noon (6 hours: $60)
- S-25. Everything You Want to Know About New Diagnostic Techniques: Scoping, Scanning, & Angiography

Monday, Dec. 6, 1976

9:00 AM-Noon (3 hours: $30 each)
- S-26. Diagnosis & Treatment of Fractures of the Lower Extremities
- S-27. Neonatology
- S-28. Current Controversies in Gynecology

2:30-5:30 PM (3 hours: $30 each)
- S-29. Basic Electrocardiography
- S-30. Pulmonary Function & Blood Gases
- *S-31. Complications of Psychotropic Drugs

Mon., Dec. 6 & Tues., Dec. 7

9:00 AM-Noon & 9:00 AM-Noon (6 hours: $60 each)
- S-32. Immunology 1976
- S-33. Thromboembolism: Prevention, Diagnosis, & Treatment

2:30-5:30 PM & 2:30-5:30 PM (6 hours: $60 each)
- S-34. Fluid & Electrolyte Therapy
- S-35. Nutrition: Parenteral & Alimentary
- S-36. Management of Diabetes Mellitus

Tuesday, Dec. 7, 1976

7:30 AM-Noon (5 hours: $50)
- S-37. Basic Life Support (CPR)

9:00 AM-Noon (3 hours: $30 each)
- S-38. Diagnosis & Treatment of Fractures in Children
- ~~*S-39. Dermatology for the Nondermatologist~~
- S-40. Allergic Emergencies
- S-41. Medical Problems in Long-Term Care
- S-42. Acute Hand Problems

1:00-5:30 PM (5 hours: $50)
- S-43. Basic Life Support (CPR)

2:30-5:30 PM (3 hours: $30 each)
- S-44. Advanced Electrocardiography
- ~~S-45. Dermatology for the Nondermatologist~~
- S-46. Complications of Psychotropic Drugs

*Course repeated. See course list for dates & times.

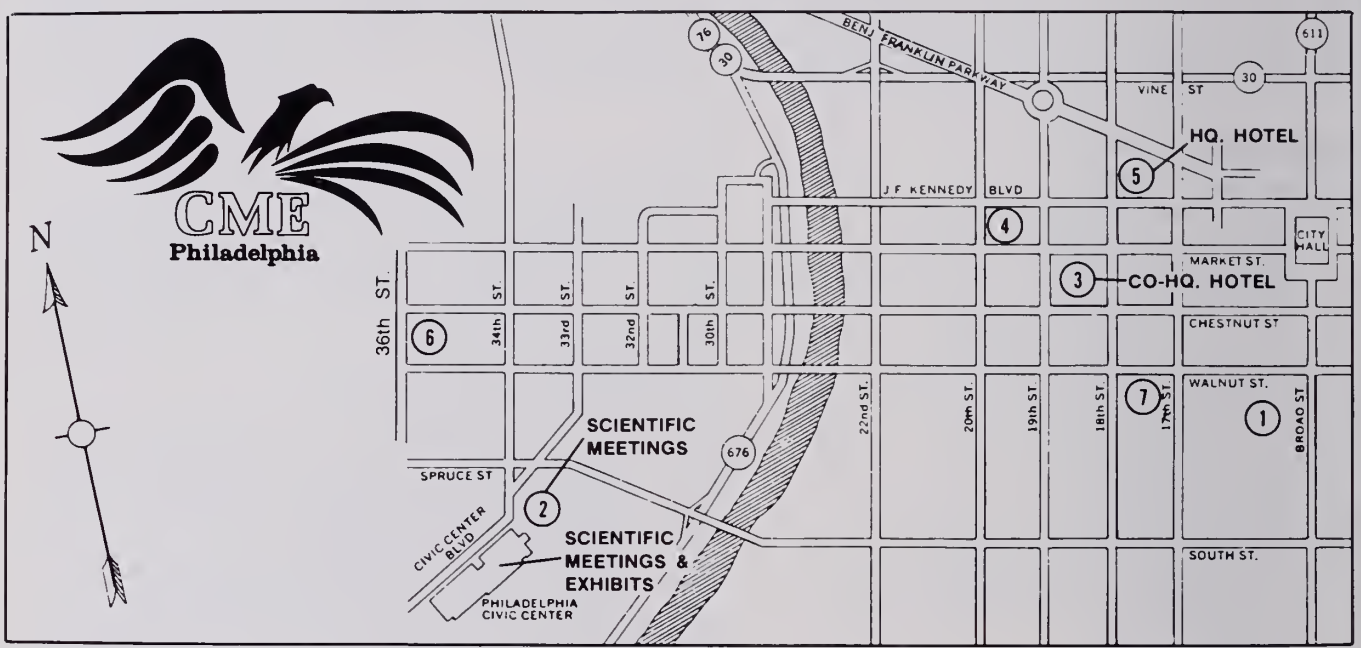
AMA HOUSING BUREAU * Suite 1420
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1617 John F. Kennedy Boulevard
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30th AMA Clinical Convention
December 4-7, 1976 • Philadelphia, Pa.

Housing Form

Key #	Hotel/Motel	Single	Double	Twin	Suite
1.	Bellevue Stratford	$27.00-40.00	$34.00-47.00	$34.00-47.00	$ 60.00-105.00 (1 Bedroom) 107.00-152.00 (2 Bedrooms)
2.	Hilton of Philadelphia	30.00-40.00	40.00-50.00	40.00-50.00	110.00-190.00 (1 Bedroom) 160.00-250.00 (2 Bedrooms)
3.	**Holiday Inn — Center City**	**CO-HEADQUARTERS HOTEL**			**NO ROOMS AVAILABLE**
4.	Penn Center Inn	25.00-27.00	30.00-32.00	30.00-32.00	60.00 (1 Bedroom) 90.00 (2 Bedrooms)
5.	**Philadelphia Sheraton**	**HEADQUARTERS HOTEL**			**NO ROOMS AVAILABLE**
6.	University City-Holiday Inn	29.00	36.00	36.00	95.00-105.00 (1 Bedroom)
7.	Warwick Hotel	32.00-38.00	38.00-44.00	38.00-44.00	75.00-100.00 (1 Bedroom) 100.00-150.00 (2 Bedrooms)

THE ABOVE RATES ARE SUBJECT TO A 6% HOUSE OCCUPANCY TAX.



American Medical Association's 1976
Philadelphia Clinical Convention

(Detach, fill out, & return this with your postage, please.)

FOR ROOM RESERVATIONS

Please print or type four choices.

1. _____
2. _____
3. _____
4. _____

Please enter my reservation at the above hotel/motel for.

Single(s) — at $ _____

Double(s) — at $ _____

Twin(s) — at $ _____

Suite(s)

1 Bedroom — at $ _____

2 Bedroom — at $ _____

Please add 6% for the House Occupancy Tax; if your rate requested is not available, the next highest rate will be assigned. **DO NOT** send your request directly to the hotel; it will only delay your confirmation. Kindly make all necessary changes and cancellations directly with the Housing Bureau in Philadelphia, and be sure and specify your time of arrival, as well as the date. If you are an Industrial Exhibitor, please specify your firm's name and the list of all the occupants for all the rooms that you are reserving.

CONFIRMATIONS WILL BE MAILED UP TO NOVEMBER 12, 1976.

Room will be occupied by:

Name _____
(Please print or type.)

Firm _____

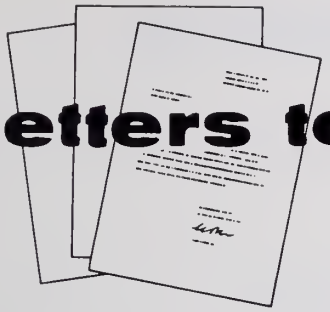
Address _____

City/State/Zip Code _____

Office Phone Number () _____ - _____

Additional Occupants (List ages of children, if any)

Arrival Date _____ at _____ AM, PM; Departure Date _____



Letters to the Editor

To the Editor: Regarding the article on leprosy in the August issue of the Florida Medical Journal, I have a patient with active leprosy in his twenties who is being followed at Carville, Louisiana on digressive therapy. He acquired the disease here in Florida on Pine Island. He has never lived out of the state of Florida; his father also had active leprosy and died within the last year of carcinoma of the prostate.

His first visit out of the state of Florida was to the Leprosarium at Carville. Diagnosis had been made on biopsy of a skin lesion. He had the usual neurological changes and had undergone surgery. He had frequent flare-ups of active leprosy requiring suppressive therapy on the average of every six months, so I take exception to the statement that "there has been no transmission of the disease in Florida for several decades."

Fred J. Burford, M.D.
Fort Myers

To the Editor: We have established an organization whose purpose is to help direct volunteer physicians to work, in various capacities, in medically needy areas of Israel. I would very much appreciate your placing the following announcement in an appropriate section of your publication.

> Israeli kibbutz doctors (English speaking) need help to provide primary care, develop patterns of care, teach medical students, etc. If you are able to provide a week or more of your time write or call: Paul Drucker, M.D., 799 Amboy Avenue, Edison, N.J. 08817, phone (201) 548-2656 or Jerry Abrams, M.D., 190 Greenbrook Rd., North Plainfield, N.J. 07060 — phone (201) 756-8513.

Thank you for your help.

Paul Drucker, M.D.
Edison, N. J.

To the Editor: Since 1937 I have been listening to addresses by outgoing presidents of medical societies in West Virginia, New Jersey and Florida. Let me state that never have I heard a better, more interesting, more gripping presentation than Dr. and Mrs. Astler gave at the House of Delegates meeting on May 5th. I know that this talk represented a tremendous amount of work, research and hours. I certainly am glad I got to hear it.

Best regards.

George P. Heffner, M.D.
Fort Lauderdale

To the Editor: I am interested in finding the incidence of allergic reactions to chocolate because of a recent query I received from a chocolate manufacturer.

I would appreciate hearing from physicians the estimated number of their patients allergic to chocolate, and the symptoms produced. I would also appreciate receiving specific case reports, results of laboratory tests and any other comments on the subject.

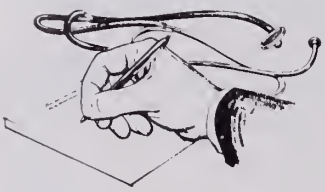
Thank you very much.

Claude A. Frazier, M.D.
Doctors Park—Bldg. 4
Asheville, N. C. 28801

Dear Doctor Weech: Just a note to tell you how much I enjoyed your delightful article on Red Tide in the June issue of the **JFMA.** I have just finished reading it and have to tell you what a pleasure it was to do so.

I hope you will find time to make further contributions to the edification and entertainment of your Florida colleagues.

Thomas M. Brill, M.D.
Gainesville



Others Are Saying

Medicaid Should Work Better

By Collins Conner
Democrat Staff Writer

Medicaid, according to HRS Secretary William Page, is a necessary bureaucracy. It offers a broad spectrum of health care to the indigent that would otherwise go unmet.

The public demanded such medical care for the poor, he says, and they got it.

There is one small problem with this concept. The doctors hate Medicaid. More than that, most of them won't participate in it.

To understand why, I ask you to consider this hypothesis: Let's say that after spending hours filling out that masterful IRS form 1040, you calculated a refund of $100.

You sent in the form, optimistically content that your efforts at filing would soon be rewarded.

Let's say further that you heard nothing from IRS for a year. But finally, after 12 long months, your answer arrived—a cryptic computer print out that said, "Refund disallowed."

Further assume that you, the taxpayer, had no recourse for contesting that irrevocable computer determination.

Now you have found yourself in the position of the doctors versus medicaid.

The doctors say it takes a road map to find their way through the Medicaid forms. This accomplished, they can expect interminable delays in processing and, in many cases, they find what they consider legitimate claims disallowed, altered or reduced arbitrarily.

And, when this happens, they have no right to debate. In that maze of bureaucracy, they are left arguing with a computerized determination made by undertrained clerks.

They maintain that rather than set the goal of comprehensive health care, the program has become bogged down in rigid standardization, overly complex systemization which inhibits physician participation rather than encouraging it.

Since medicine is an inexact science that doesn't lend itself to that kind of rigidity, the doctors seek some kind of participation in the Medicaid programming as it applies to the care of the patients.

At the very least, professional collaboration would make the program more functional for the average practicing M.D.

While sympathizing with their grievances, Secretary Page suggests that the doctors seek to dabble in what is essentially a government program. He also suggests that the same process which complicates the program for the doctors prevents the filing of fraudulent claims by disreputable physicians.

I disagree on both counts.

First, since the program is contingent on the voluntary compliance of the medical community, it seems evident that it must interact smoothly with that community. It only makes sense that a program which offers health services should integrate professional guidance in its procedures.

Second, what the complexity of Medicaid bars on the one hand, it tends to invite on the other. When the average doctor finds it too difficult to participate, the occasional doctor has a ready market of anxious patients ripe for the picking, and therein lay the harvest of those frudulent claims the government says it's so anxious to prohibit.

It does no good to have a program which pits the physicians against the bureaucracy.

It isn't helping the patient. And that's what Medicaid is supposed to do. Isn't it?

Reprinted from the Tallahassee Democrat, April 28, 1976.

Submitted to the Journal by Dr. Louis B. St. Petery Jr. of Tallahassee.

The Art of Delivering Bad News

Every physician derives satisfaction from delivering good news to a patient; and no physician that I know enjoys delivering bad news. Still, there are rare occasions when it becomes necessary for the physician to disclose a fatal or crippling diagnosis and prognosis to the patient. There is no greater test of the physician's skill and courage than this task of delivering medical bad news. Some physicians delay or avoid this unpleasant task for fear of provoking an emotional scene which they are ill prepared to handle, fear of producing a serious depression, or perhaps fear of losing the trust and confidence of the patient. All of these are valid possibilities which need to be considered.

There are as many ways of handling bad news conferences as there are physicians. There is probably no "right" way, and no "wrong" way to handle this. No thinking physician would use the same stock techniques with every patient. Patients are much too different and too sophisticated to be handled in such a fashion. The particular method of delivering bad news must be varied to meet the needs of the situation. The following are some general guidelines that I have found useful over the years. Most of these rules are not original with me, but I haven't found a single source that covers the subject.

1. **Keep it simple.** Perhaps as a result of apprehension or uneasiness, there is a tendency to go into too many details and technicalities.

2. Ask yourself, **"What does this diagnosis mean to this patient?"** Many patients are simply unable to comprehend the nature of the diagnosis, in which case methods must be found to gradually educate them.

3. **Meet on "cool ground" first.** It is very unpleasant to walk in to meet people whom you have never met before, knowing you have to give them a piece of really bad news. It is always easier to handle if you have some earlier relationship to the patient or his family, and have some notion of their background and possible reactions to the news.

4. **Don't deliver all the news at once.** It is a good idea to try not to provide too much information at the first sitting. People have a marvelous way of letting you know how much they are able to handle. Like the newspaper that printed "all the news that's fit to print," I feel that the patient has the right to all information that he is prepared to handle. This may mean that the full disclosure has to be spread out over two or three sessions.

5. **Wait for questions.** A long pause will allow the question that tells you where to go next.

6. **Do not argue with denial.** A characteristic response in many patients is outright denial of the reality of the situation. No matter how illogical the denial, it is serving a purpose, and there is nothing to gain by battering down the denial with logic. This usually leads to loss of rapport with the patient. In general, the patient will "hear" the message when he is ready to accept it. It is sufficient that he has been told at least once in some form that condition "x" has been discovered.

7. **Ask questions yourself.** Ask the patient to tell you what you have told him, or ask him what it means. Oftentimes you will be surprised at the answer. Or, ask the patient what the doctors at such-and-such a hospital have told him.

8. **Do not destroy all hope.** There are a hundred ways of handling this, and it requires real tact and experience to be able to acquire the necessary skill. "Most people with this kind of injury don't walk again" is a useful kind of treatment.

9. **Do not say anything that is not true.** This would be a most cruel blow of all.

Again, perhaps there is no right way, only varying degrees of wrong ways. The assistance of a minister, social worker, nurse, or friend may be invaluable. Common sense and human compassion are the prerequisites for the physician who must artfully deliver the bad news.

Howard P. Hogshead, M.D.
Jacksonville

Reprinted from the Editorials—Letters—Viewpoints section of Jacksonville Medicine, August 1976.

MEETINGS

Approved by FMA Committee on Continuing Medical Education

OCTOBER

First Annual Reunion, University of Miami, Department of Family Medicine, Oct. 3-5, Americana Hotel, Miami Beach*

American Group Practice Association, Oct. 5-8, Americana Hotel. For information: AGPA, 20 South Quaker Lane, Alexandria, Va. 22314.

Obstetric/Gynecology Review Course, Oct. 2-10, Miami*

Topics in Family Medicine 1976, Oct. 6-10, University of Miami School of Medicine, Department of Family Medicine*

Review Course on **"Fundamental and Clinical Aspects of Internal Medicine,** Oct. 10-23, Key Biscayne Hotel, Miami*

Fourth Family Practice Review, Oct. 11-16, Gainesville Hilton, Gainesville**

Neurology for Non-Neurologists IV—Stroke, Oct. 14, Tampa.+

Cardiology at Sandpiper Bay, Oct. 14-17, Port St. Lucie. For information: Harold J. Lynch Jr., M.D., 205 Datura Street, West Palm Beach 33401.

17th Workshop in Electrocardiography for Cardiac Nurses & Interested Physicians, Oct. 14-18, Tides Hotel, Redington Beach, St. Petersburg. For Information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

25th Basic Colposcopy Course, Oct. 15-17, Sonesta Beach Hotel, Key Biscayne. For information: Charles B. Slack, Inc., 6900 Grove Rd., Thorofare, N.J. 08086

Second Pan American Seminar, October 18-22, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Obstetrical & Gynecological Review Course, Oct. 18-23, Sonesta Beach Hotel, Key Biscayne.*

Immunologic and Pharmacologic Advances in Diagnosis and Treatment of Allergic Illness, Oct. 21, Tampa.+

FSIM/ACP Joint Fall Meeting 1976, Oct. 22-24, Marco Beach Hotel and Villas, Marco Island. For information: Florida Society of Internal Medicine, 515 Lomax St., Jacksonville 32204

Gastrointestinal Bleeding: Diagnosis and Management, Oct. 28, Tampa.+

A Functional Analysis Approach to the Treatment of Alcohol Problems, Oct. 30, Holiday Inn Airport, Orlando. For information: Francis C. Walker, 1211 North West Shore Blvd., Suite 105, Tampa 33607.

NOVEMBER

Program for Foreign Medical Graduates, Nov. 1 & Jan. 22, Miami*

Computed Tomography of Body and Head—Current Concepts, Nov. 1-5, Tampa.+

Pigskin Review in Obstetrics and Gynecology, Nov. 5-6, Hertz Skycenter Inn, Jacksonville.**

Sixth George Papanicolaou Memorial Seminar, Nov. 10, The Rivergate, New Orleans, Louisiana. For information: George Ioannides, M.D., St. Francis Hospital, Miami Beach 33141.

Interdisciplinary Seminar, Nov. 11-12, South Building Auditorium, Cedars of Lebanon Health Care Center, Miami. For information: N. Joel Ehrenkranz, M.D., 1400 Northwest 12th Avenue, Miami 33136.

Hepatobiliary Disease in Clinical Practice, Nov. 11-13, Miami*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 11-13, Miami*

Fall Meeting, Florida Society of Otolaryngology, Nov. 11-14, Sandpiper Bay, Port St. Lucie. For information: R.A. Bagby, M.D., 503 DeLeon, Tampa 33606.

The Cytologic Void: Urine Cytology, Nov. 13, Lakeland General Hospital, Lakeland. For information: James L. Holiman, M.D., 1417 Lakeland Hills Boulevard, Lakeland 33801.

Pediatric and Adolescent Echocardiography Course—Update '76, Nov. 13-14, Deauville Hotel, Miami Beach. For information: Stanley J. Goldbert, M.D., Univ. of Arizona, Arizona Medical Center, Tucson, Arizona 85724.

Pacemakers Updated, Nov. 13-14, Deauville Hotel, Miami Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

Initial Management of the Pediatric Emergency, Nov. 17-21, Caesars Palace, Las Vegas, Nevada. For information: J. Clifford Findeiss, M.D., 3900 Northwest 79th Avenue, Suite 469, Miami 33166.

Legal and Medical Aspects of Human Sexuality, Nov. 18-20, Miami*

Facial Anomalies Symposium, Nov. 18-19, Tampa.+

Third Workshop in the Use of Staplers in Surgery, Nov. 19-20, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Pediatric Emergencies—Little People, Big Problems, Nov. 21-24, Hyatt House, Orlando. For information: Registrar, Pediatric Emergencies, 1919 Beachway Road, Suite 5C, Jacksonville 32207.

Anesthesia Management for the Surgical Patient, Nov. 29-Dec. 12, Miami*

Emergencies in Internal Medicine, Nov. 30-Dec. 4, Miami*

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

DECEMBER

Death and Dying: Education, Counseling, and Care, Dec. 1-3, Hyatt Hotel, Orlando. For information: Suzan Schafer, M.D., 807 Seagle Building, Gainesville 32601.

Emergencies in Internal Medicine: Diagnosis and Management, Dec. 1-4, Americana Hotel, Miami Beach*

Fall Meeting Florida Society of Ophthalmology, Dec. 2-5, Marco Island Hotel and Villas, Marco Island, Florida. For information: Susan Waits, Florida Society of Ophthalmology, 346 Barnett Bank Bldg., Tallahassee 32301.

Symposium on Pathology, Dec. 7, Watson Clinic, Lakeland. For information: Eugene T. Davidson, M.D., Watson Clinic, Lakeland 33802

AMA Scientific Assembly, Dec. 10-13, Miami. For information: AMA, Dept. of Continuing Education, 535 N. Dearborn St., Chicago 60610

JANUARY

Pediatric Nephrology Seminar IV, Jan. 3-6, Miami*

Neuro-Ophthalmology Seminar, Jan. 3-7, Miami*

Initial Management of the Pediatric Emergency, Jan. 5-9, Konover Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Midwinter Cruise—Symposium on Intensive Care, Jan. 6-15, Miami*

Family Practice Weekend, Jan. 8, Tampa.+

Miami Winter Symposia—Biochemistry, Jan. 10-14, Miami*

Human Disease Related to Food and Chemical Sensitivity, Jan. 12-15, Miami*

11th Annual Postgraduate Seminar in Surgery, Jan. 12-15, Miami*

Hematology and Oncology 1977, Jan. 13-16, Miami*

Nephrology 1977, Jan. 14-15, Miami*

Pulmonary Disease 1977, Jan. 14-15, Miami*

Arthritis 1977, Jan. 14-16, Miami*

Gastroenterology and Hepatology 1977, Jan. 14-16, Miami*

Internal Medicine 1977, Jan. 15-21, Miami*

Second Review and Practical Advances in Pathology, Jan. 16-21, Miami*

Southeastern Breast Oncology Conference, Jan. 17-21, Marriott Hotel, Miami. For information: Oswald H. Coury, M.D., 7211 Southwest 62nd Ave., South Miami 33143.

9th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-22, Carillon Hotel, Miami Beach. For information: Charles Lynne, M.D., 1200 N.W. 10th Avenue, Miami 33136

19th Annual Cardiovascular Seminar, Jan. 21-22, Tampa.+

Infectious Disease—Immunology 1977, Jan. 22-23, Miami*

Endocrinology 1977, Jan. 22-23, Miami*

Basic Sciences for the Practicing Physician: Biochemistry, Jan. 22-23, Miami*

Cardiology 1977, Jan. 24-26, Miami*

4th Annual Postgraduate Course in Practical Modern Neurology, Jan. 24-27, Miami*

Emergency Cardiac Care—1977, Jan. 27-30, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Florida Midwinter Seminar on Ophthalmology, Jan. 30-Feb. 2, Miami*

First International Glaucoma Congress, Jan. 31-Feb. 1, Diplomat Hotel, Hollywood. For information: John Bellows, M.D., 6 North Michigan Avenue, Chicago, Illinois 60602.

FEBRUARY

Update on Cancers of the Gastrointestinal System, Feb. 3-5, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Florida Midwinter Seminar on Otolaryngology, Feb. 3-5, Miami*

What's New in Neurosurgery for the General Practitioner, Feb. 4-5, Gainesville Hilton, Gainesville.**

Fred J. Wood Lecture Series III, Pediatrics and Adult G.U. Cancers, Feb. 4-5, Tampa.+

22nd Central Florida Medical Meeting, Feb. 4-6, Contemporary Resort, Lake Buena Vista. For information: Axel W. Anderson III, M.D., Suite 403, 85 West Miller Avenue, Orlando 32806.

3rd Annual Vail Conference in Anesthesiology, Feb. 5-12, Miami*

Thrombosis: Diagnosis, Prevention & Treatment, Feb. 7-9, Sonesta Beach Hotel, Key Biscayne. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Second Annual Seminar, Problems in Pediatric Radiology, Feb. 8-12, Dutch Inn, Lake Buena Vista.*

Symposium on Stroke—Moderns Trends In Cerebrovascular Disease, Feb. 9-12, Diplomat Hotel, Hollywood. For information: Mr. Ronald A. Nelson, Executor Director, Heart Association of Broward County, 440 N. Andrews Ave., Fort Lauderdale 33301

Midwinter Seminar in Ob/Gyn, Feb. 10-12, Tampa.+

Winter Management (Anesthesiology), Feb. 12-19, Miami*

Pediatric Dermatology Seminar, Feb. 24, Konover Hotel, Miami Beach. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Avenue, N. Miami Beach 33169.

Recent Advances in Cardiopulmonary Care III, Feb. 25-26, Holiday Inn, Lido Beach, Sarasota. For information: Robert E. Windom, M.D., 1901 Arlington Street, Sarasota 33579.

Basic Neurology for Psychiatrists, Feb. 28-Mar. 4, Miami*

MARCH

Third Annual Pediatric Surgical Postgraduate Course, Mar. 3-5, Americana Hotel, Miami Beach. For information: William T. Brown, M.D., Chief, Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155.

Postgraduate Seminar in Dermatology, Mar. 4-6, Miami*

Skin 1977: What Every Nurse Should Know, Mar. 4-6, Miami*

Pediatric Anesthesia Seminar—Spring Cruise, Mar. 5-15, Miami*

3rd Annual USF Cancer "Tumors of the Genitourinary Tract," March 5, Tampa.+

Annual Suncoast Trauma Seminar, March 9-11, Tampa.+

A Symposium in Gynecologic Endocrinology and Infertility, March 10-12, Hyatt House, Orlando. For information: B. Cantor, M.D.**

Basic Medical Hypnosis, Mar. 13-19, Miami*

Neurology for Non-Neurologist V: Movement Disorders, March 17, Tampa.+

Seventh Annual Special Radiological Procedures Seminar, Mar. 19-22, Konover Hotel, Miami Beach.*

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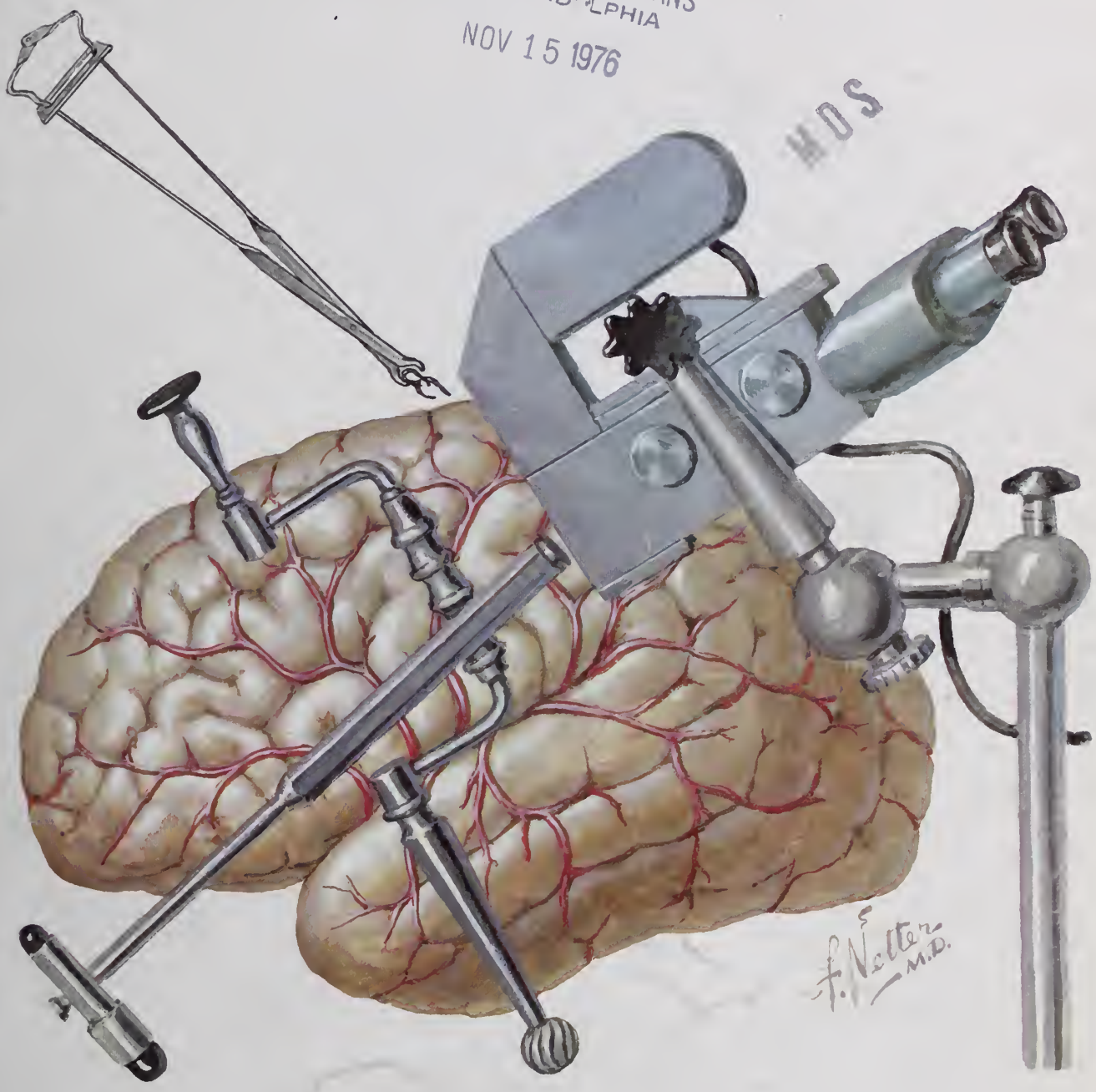
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SPECIAL ISSUE

NEUROLOGICAL SURGERY

ALBERT L. RHOTON JR., M.D.
GUEST EDITOR

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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Special Issue
Neurological Surgery

(See opposite page for contents)

ACKNOWLEDGEMENT: The members of the Florida Neurosurgical Society extend their appreciation to the Journal and its Editors for this opportunity to review current practices in Neurological Surgery.

This literary effort was made possible through the involvement of the members of the Florida Neurosurgical Society, and in particular the authors of the articles in this publication, who shared the production costs of this special issue.

We acknowledge the financial assistance of Codman, Inc. and Ruggles, Inc.

Sections

President's Page
Thanksgiving
JACK A. MACRIS, M.D. 823

Books Received 935

Book Reviews 934

Commentary
Medical Crusade Moss Has Evidence But Little Help
JAMES KILPATRICK 926
Rebuttal to Mr. Kilpatrick by
THOMAS M. BRILL, M.D. 927

Dean's Page
The Last Page
DONN L. SMITH, M.D. 826

From the Editor's Desk 830

Medical News Around the State 930

Organization
Journal Wins Major Award in Statewide Contest ... 917
Preliminary Program for 103rd FMA Annual Meeting Scientific Session 918
Summary of FMA Board of Governors Meeting, October 7-9, 1976 914a

Others Are Saying
Middle Class—A Sensible Society
LEES M. SCHADEL, M.D. 915
Patient Recall
F. NORMAN VICKERS, M.D. 915

Information

Classified Advertising 943

FMA Officers and Council Chairmen 946

Index to Advertisers 946

Meetings 940

Statement of Ownership 942

NOVEMBER COVER — The Journal of the Florida Medical Association and the members of the Florida Neurosurgical Society extend their sincere appreciation to Frank H. Netter, M.D., America's outstanding medical illustrator, for the cover illustration. The cover shows the cerebrum and some neurosurgical instruments. The reflex hammer emphasizes the importance of diagnostic neurology in neurosurgical practice. The trephine is an instrument of historic importance which has been largely replaced by air and electric drills. The surgical microscope in the upper right and the aneurysm clip applier in the upper left emphasize the application of modern techniques in neurosurgery.
This is the second cover Dr. Netter has done for the Journal. The first was for the Special Issue on Dermatology in January 1976 which won wide acclaim.

TABLE OF CONTENTS

SPECIAL ISSUE ON NEUROLOGICAL SURGERY

Introduction:
Thomas O. Brackett, M.D., Robert S. Tolmach, M.D. and Albert L. Rhoton Jr., M.D., Paul C. Bucy, M.D., Lester A. Mount, M.D., Bruce F. Sorensen, M.D. and Courtland H. Davis Jr., M.D. 835

Pioneering in Neurological Surgery in Florida
James G. Lyerly Sr., M.D. 837

Recent Advances in Diagnosis and Treatment of Primary Intracranial Tumors
Arthur L. Day, M.D. and Francisco Garcia-Bengochea, M.D. 840

Transsphenoidal Hypophysectomy in Metastatic Breast Cancer
Glenn Morrison, M.D. 844

Cerebral Aneurysm
Gaston J. Acosta-Rua, M.D., James G. Lyerly Sr., M.D., Edward J. Sullivan Jr., M.D., James G. Lyerly Jr., M.D. and Howard C. Chandler, M.D. 847

Microsurgical Treatment of Neurovascular Disease
Albert L. Rhoton Jr., M.D. 850

Surgical Therapy of Epilepsy
George W. Sypert, M.D. 855

Head Injuries in a Community Hospital: Day-to-Day Management
Thomas E. Scott Jr., M.D. and C. Gilbert Tweed, M.D. 860

Normal Pressure Hydrocephalus-A Treatable Cause of Dementia
Hank H. Gosch, M.D. 863

Intracranial Pressure Monitoring in Clinical Practice
John K. Vries, M.D. 865

Cranioplasty: Use of a Combination Graft
Jack E. Maniscalco, M.D., Donald Leake, D.M.D., M.D. and Mutaz B. Habal, M.D. 869

Cervical Disc Disease and Other Causes of Upper Extremity Pain
James D. Geissinger, M.D. and Frank M. Davis, M.D. 872

Cervical Spondylosis
J. Robert Mozingo, M.D., C. Jin Whang, M.D., Joseph C. Cauthen, M.D. and Warren D. Wilson, M.D. 876

Traumatic Unilateral Facet Locking in the Cervical Spine
Horace Norrell, M.D. 880

Bony Encroachment of the Lumbar Spine
A Cause of Low Back Surgery Failure
Hubert L. Rosomoff, M.D. 884

Chronic Spinal Radiculopathy With Particular Reference to Spinal Arachnoiditis
A Surgical Viewpoint
A. W. Auld, M.D. 889

Neurosurgical Care of the Patient With Spina Bifida Aperta
Larry K. Page, M.D. and F. Tod Welch, M.D. 892

A Synopsis of the Neurosurgical Treatment of Pain
Paul W. Kramer, M.D. and Gerald F. Meier, M.D. 895

Selective Percutaneous Radiofrequency Coagulation of Gasserian Ganglion for Trigeminal Neuralgia
John S. Boggs, M.D. 898

Stereotactic Percutaneous Cordotomy
Ralph E. Rydell, M.D. 900

Electrical Modulation of Nervous System Function
Charles Burton, M.D. 902

Peripheral Nerve Stimulation for Pain Control
Jorge A. Picaza, M.D. 903

Electrical Stimulation of the Spinal Cord in Patients With Demyelinating and Degenerative Diseases of the Central Nervous System
Donald M. Dooley, M.D., Mary Kasprak, R.N. and Marie Stibitz, R.N. 906

Cerebeller Stimulation for Cerebral Palsy
Ross Davis, M.D., Robert F. Cullen, M.D., Danilo Duenas, M.D. and Howard Engel, M.D. 910

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President's Page

Thanksgiving

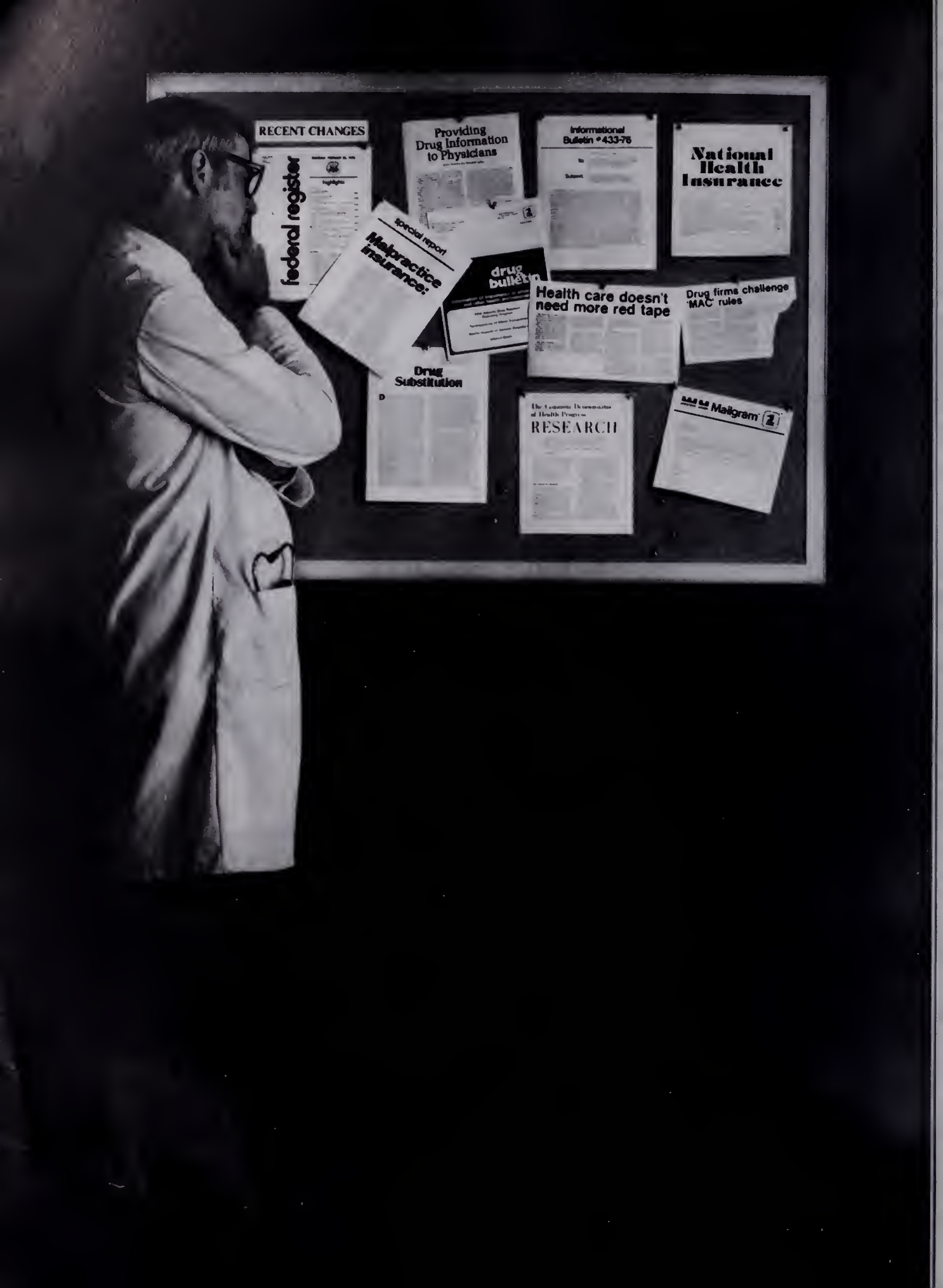
As we enter the Holiday Season, we become reflective in our thoughts. Stimulated by pictures of Pilgrims, turkey dinners, and sounds of Christmas music, we are relieved to turn away from the daily pattern of hospital rounds, office hours, liability insurance, inflation, the week's foreign crisis, the leaky faucet, and the lawn sprinklers that won't turn. We are reminded of the tribulations and hardships those first immigrants endured when they settled this land and success was measured merely by survival. In contrast, our air-conditioned lives, air travel, the artificial heart, and pictures taken on Mars, show how far we have come. No wonder that we sometimes lose our perspective in the overall view of our lives. Values tend to give way to material comfort, and technological progress and principles give way to expediency. We are admonished not to stand in the way of "progress."

We need to let our Holiday Season replenish our spirits, just as Spring replenishes the earth. We need to become more aware of our values and priorities and try to regain our perspective. Hopefully, we reshuffle our priorities and become more mindful of where we are going.

We have many things in our lives for which to be thankful, but as physicians we have a special gratitude for the opportunity of spending our waking days making sick people well again. Few fields of endeavor yield such immediate satisfaction as restoring health and a sense of well-being to a sick patient.

Let us be thankful for our blessings and mindful of the needs of those around us. I wish a Joyous and Happy Holiday Season to all of you.

Jack A. Wallis, M.D.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



Dean's Page

The Last Page

Donn L. Smith, M.D.

As I write my last contribution as a Medical Dean to the Journal, let me express my sincere gratitude to the Association; I came as a stranger and was made to feel at home in a manner most thoughtful and generous. Incidently, it has been my pleasure in a very private sort of way to help supervise the medical education and observe the progress of a number of sons and daughters of members of the Association. It is clear that some of these youngsters will be as good or better than the parent physician which perhaps may be considered a very adequate yardstick for the measurement of the quality of the educational program at the University of South Florida College of Medicine.

As I take leave of the bureaucratic misadventure that characterizes the Office of the Dean in this day and age, a few reflections may be in order. Most of the significant thoughts that remain prominently in my mind revolve around medical students and faculty. I note, for example, that in the five years students have been enrolled at our College, there has not been a single case of disciplinary action required. The student honor code instituted by the charter class has not been violated and the student honor council has not found it necessary to submit a single report to the Office of the Dean. These facts speak well for the admissions process at this College, in which maturity, motivation and personal attributes have outweighed scores and grades in the selection process. Student-faculty relationships are warm and have from the beginning been based on a healthy mutual respect. In spite of an almost crushing academic load, medical student teams have won honors in the University intramural sports program. It has been a distinct pleasure and a rewarding experience to work with these physicians of tomorrow, and it will be even more rewarding to be actively engaged in teaching them in days to come. The fact that we have been unable to obtain physical fitness and sports facilities or equipment at the Medical Center has been disappointing and inexplicable. On the other hand our excellent library facility with a seat for every student has been a useful and well used tool for our students. Our graduates are achieving superior ratings as house-staff in University Medical Centers from coast to coast much to the delight and reassurance of the faculty.

The young and vigorous medical faculty has developed and matured at the same accelerated rate at which we have tried to do almost everything and an aura of urgency still pervades the shiny new halls of the College. Investigative activity and research contributions are beginning to flow from the College at the national scientific level.

These observations, along with others, allow me to return to the Faculty of Medicine with a feeling that in the composition and motivation of the student and faculty bodies the necessary and significant critical mass has been achieved that will carry the College to a level of distinction that will earn this institution a place of respect and admiration in the hearts and minds of the physicians and other citizens of the State.

If this last contribution sounds like an ode to the students and faculty of the University of South Florida College of Medicine, so be it. They have individually and collectively provided me with a pleasant, stimulating and, in some ways, a memorable experience. I will always be grateful for that, as well as for the friendly and supportive actions of the Florida Medical Association and a far too large number of its members to enumerate.

Dr. Smith, University of South Florida, Tampa 33620.

Dr. Smith resigned as Dean of the College of Medicine and Director of the Medical Center at the University of South Florida on September 15. He will serve on the faculty as Professor of Medicine and Physiology.

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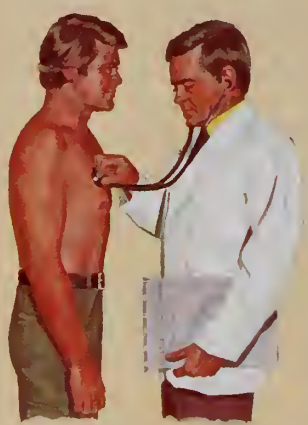
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Narrowing down pneumonias

Upjohn

Bacterial or nonbacterial?

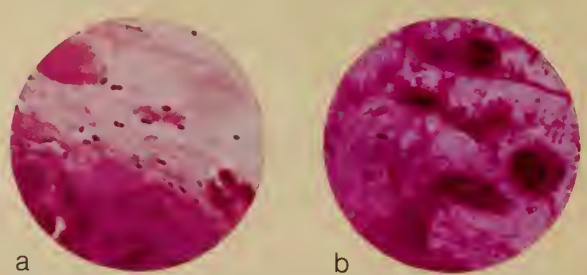
In the early stages of mild to moderate pneumonia, it is often difficult to reach an accurate bacteriologic diagnosis. A tentative differentiation may be made on history-taking, physical examination, CBC with differential analysis, and microscopic study of the sputum smear. Specimens should be obtained for culture and sensitivity testing, but when a bacterial pneumonia is diagnosed, therapy is often instituted before the etiological agent is positively identified.



Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae,* still by far the most frequently encountered agent in bacterial pneumonia.[1] The CBC reveals marked leukocytosis with a shift to the left.

In *nonbacterial pneumonias*—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.

Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).



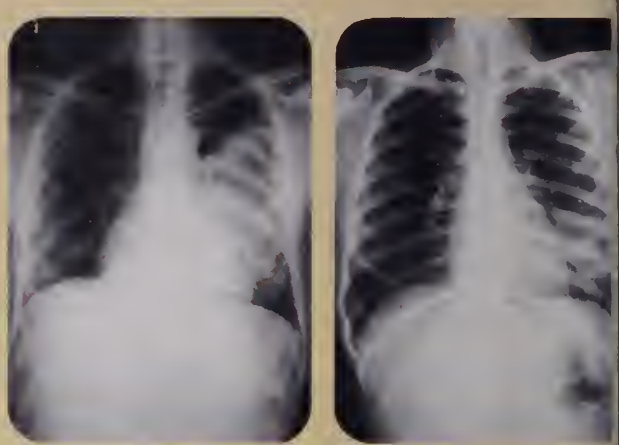
a b

Mycoplasmal or viral?

Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.

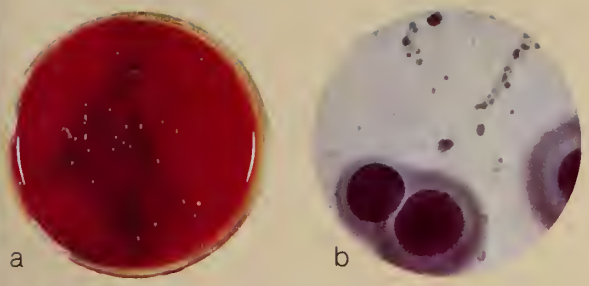
Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity c the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturi *M. pneumoniae* are not widely available.[3]

If treatment is to be initiated, therefore, it may b necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.[1-3] In reachir such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of th patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.[1]



a b

Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung; (b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



(a) Distinct mucoid colonies of type 3 pneumococci *(Streptococcus pneumoniae)* on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with lighter periphery. Cultural and serologic methods for detecting *M. pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

the patient with a presumptive diagnosis of ycoplasmal pneumonia or bacterial pneumonia, it ay be desirable to initiate antibiotic therapy before ulture and sensitivity results are available.

A course of erythromycin or tetracycline is onsidered effective in the treatment of mycoplasmal neumonia to help speed the clearing of infiltrate and horten the duration of symptoms.[1,3] In pneumococcal neumonia, erythromycin is an effective alternative to enicillin, the drug of choice. A recent report, based n data from 200 hospitals of 100 beds or more, found 8% of *S. pneumoniae* sensitive *in vitro* to rythromycin.[4]

Among these therapeutic agents, only rythromycin provides effective coverage of both *lycoplasma pneumoniae* and *S. pneumoniae*. The enicillins are not effective against *Mycoplasma,* and *. pneumoniae* has shown a relatively high incidence f resistance to tetracycline.

When erythromycin is selected for therapy, -Mycin (erythromycin enteric-coated tablets, Upjohn) s a good choice. E-Mycin is administered and bsorbed as active erythromycin base, and may be aken q.i.d., q 6h, or b.i.d., immediately after meals or etween meals. Thus, patients can use mealtimes to elp them remember their medication. The enteric oating on E-Mycin tablets helps ensure efficient bsorption in the intestinal tract, and bioavailability tudies show that E-Mycin can be expected to roduce predictable, acceptable blood levels. The ow cost of E-Mycin helps assure economical therapy.

E-Mycin rarely causes serious side effects and is ot associated with liver toxicity.* The most frequent ide effects are upper gastrointestinal, such as bdominal cramping and discomfort, and are dose-elated. Nausea, vomiting, and diarrhea occur nfrequently with usual oral doses. Serious allergic eactions, including anaphylaxis, have rarely been eported.

Use cautiously in patients with severe liver impairment.

REFERENCES: 1. Chusid EL, Dalrymple W, Holloway WJ, et al. Managing the infectious neumonias. *Patient Care* 9:122-167, 1975. 2. The occasional might of mycoplasma. *mergency Med* 7:82, 85, 1975. 3. Stevens DA: Viral and Mycoplasma pneumonias. *ostgrad Med* 55:81-86, 1974. 4. Data source: PMR Bacteriologic Report, Winter Series 1975-1976. Data are a compilation of laboratory reports submitted during December 1975 and January and February 1976 by 200 acute care hospitals of 100 beds or more

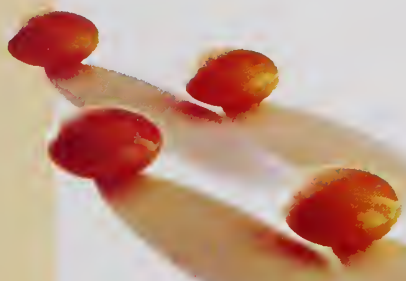
Please turn page for brief summary of prescribing information.

Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.

Erythromycin is an effective antibiotic against *Mycoplasma pneumoniae, Streptococcus pneumoniae,*† and *Streptococcus pyogenes.*† E-Mycin (erythromycin enteric-coated tablets, Upjohn) is administered and well absorbed as the active base, may be taken immediately after meals or between meals, and is essentially nontoxic.

†Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative.



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Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)
Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.
Diplococcus pneumoniae: Upper respiratory tract infections, (eg, otitis media, pharyngitis) and lower respiratory tract infections (eg, pneumonia) of mild to moderate degree.
Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.
Treponema pallidum: Infections due to this organism.
Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.
Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.
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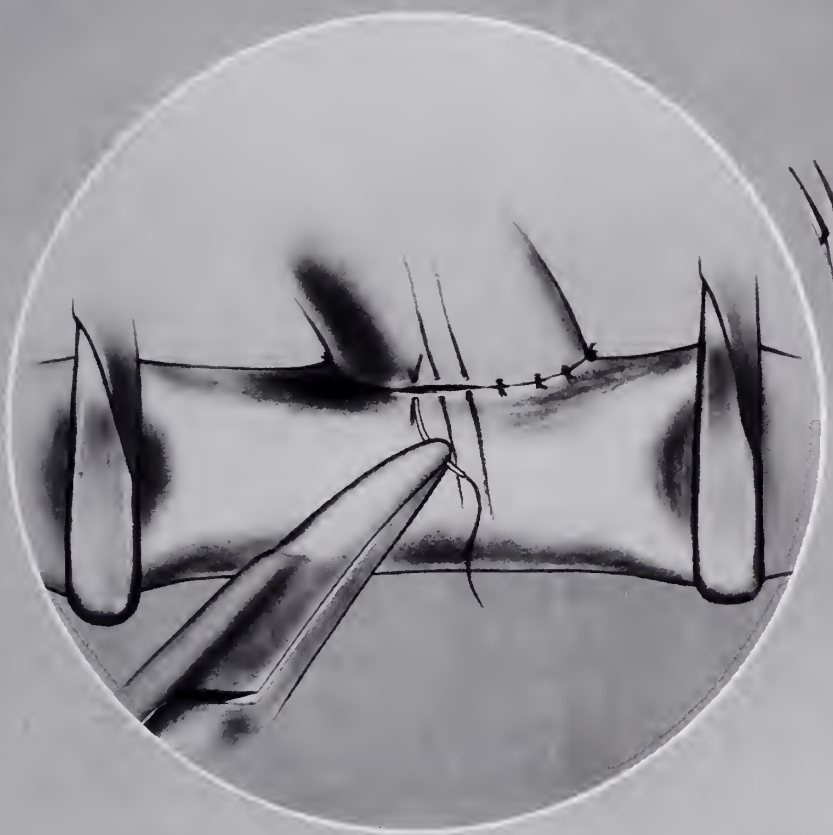
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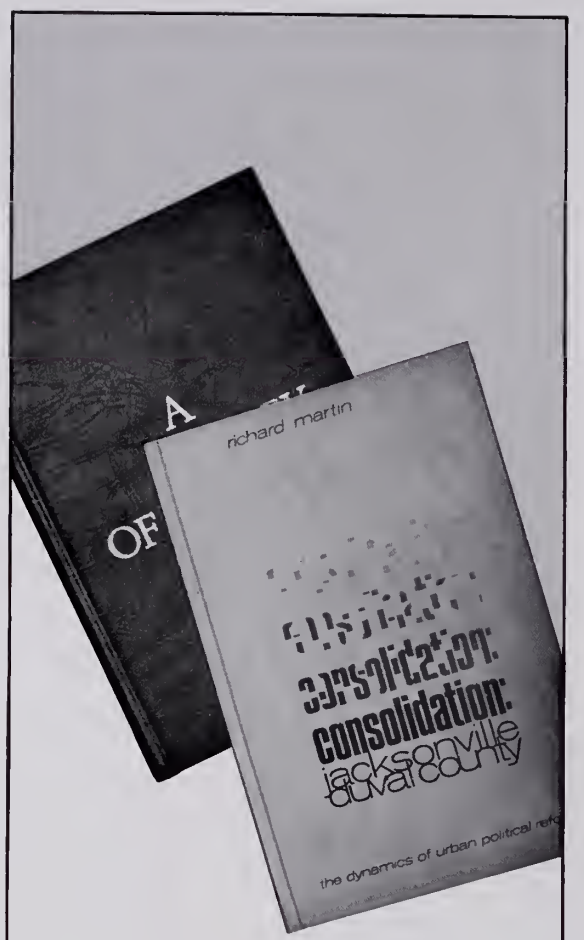
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The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

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FROM THE EDITOR'S DESK

Stripped of many of its objectionable features, a three-year $2 billion medical education assistance bill was passed by Congress in the last days of its 1976 session. The AMA, the Administration and others successfully resisted efforts to use the so-called Health Manpower Bill as a vehicle for federal involvement in curriculum, regional allocations and licensure. One feature of the bill grants capitation funds to medical schools at the rate of $2,000 per student for the coming fiscal year, increasing to $2,100 for fiscal 1980.

One controversial feature that was dropped would have compelled medical graduates to pay back, either in money, or service in shortage areas, the capitation funds. In the opinion of AMA, the only major troublesome provision remaining requires medical schools, as a condition for capitation aid, to have in 1978 at least 35 per cent of their filled first year positions in direct or affiliated residency training programs in primary care. These are defined as Family Medicine, General Internal Medicine and General Pediatrics. The percentage rises to 50% by 1980. The legislation also provides scholarship funds sufficient to assure an adequate number of young physicians will enter the National Health Service Corps; and requires alien foreign medical graduates to return to their country of origin after training.

* * * *

Morris Fishbein, M.D., one of the best-known names in American Medicine in the 20th Century, died in Chicago on September 27 at the age of 87. A noted writer and lecturer, Dr. Fishbein joined the AMA staff in 1913 as assistant editor of The Journal of the American Medical Association, rising in 1924 to Editor, a position he held for a quarter century. From the Editor's chair he waged war on quackery and was identified with many other issues related to medicine. In more recent years he became a popular figure among the lay public through his authorship of magazine health columns.

* * * *

As all physicians know, the federal regulatory agencies such as the Food and Drug Administration, are armed with potent rule-making authority. The regulations they publish have the effect of law. All of these "laws" find their way into the Federal Register, which last year contained 60,221 pages, a gain of 14,000 over the previous year. There's a message in those figures.

* * * *

The Department of HEW has begun to establish Medicare Review Teams in all 50 states. The teams, each consisting of four physicians, three other health providers and two consumers, will examine Medicare cases for possible provider abuse and establish due process procedures for the accused. Under the law, HEW must consult with medical societies in appointing the teams. AMA has opposed these provisions as being duplicative of PSRO.

* * * *

The Department of HEW has opened the door to broad public participation in its rule-making function. "For far too long HEW has gone to the public . . . only to tell them what it intends to do," says HEW Secretary David Mathews. "From now on our first step will be to ask the people of this country what they think we should do." He adds: "We will not put forward a major proposal until the people affected by it have their say." The Department will communicate with the public through town hall-type meetings, advertisements, public service announcements, news releases, professional and service organizations, mailings, the Federal Register and regional offices.

* * * *

Florida has been gearing up for the national Swine Flu Immunization program, which was sched-

uled to start in October. In a memorandum to the FMA membership, President Jack A. MaCris, M.D., noted that physicians participating in a public mass immunization clinic, where vaccinations are at no cost to the public, will be protected by law from any direct liability. The Department of HEW has developed consent forms to be signed by individuals to be immunized. Physicians may not charge their private patients for the vaccine, and those who charge for administration will not be protected under the federal liability law.

* * * *

Along these lines, the American Academy of Pediatrics has recommended that certain "high risk" children be given the swine flu vaccine. These are children with chronic bronchopulmonary disease, heart disease, chronic renal disease, chronic neuromuscular disorders, chronic metabolic disorders, malignancies and immunodeficient states. The Academy's recommendation includes children of three to 18 years of age.

* * * *

The Carnegie Foundation says the U.S. is in danger of building too many medical schools. Only six years ago the same Foundation recommended medical school expansion. Now, the Foundation finds. the chief reason for new medical schools "is to achieve more adequate geographical distribution of schools."

* * * *

The AMA has called on the government to get tough with Medicaid abusers. A statement from AMA Executive Vice President James H. Sammons came on the heels of a Senate report that from one-fourth to one-half of the $15 billions spent on Medicaid this year will be lost through abuse and fraud by both providers and recipients. "Let's not have a witch hunt," Dr. Sammons said, "but let's have aggressive action." Several months ago, AMA announced it would participate in an HEW program to "help curb the dishonest activities of some Medicaid providers and clear the image of the overwhelming majority who are honest."

* * * *

AMA will conduct a series of six Young Physician Practice Management Workshops at its Chicago Headquarters beginning in February. The two-day sessions are open to physicians in their final year of residency. These are separate and apart from the Practice Management Workshops presented in conjunction with county medical societies and the Financial Management and Practice Management Workshops sponsored by the AMA Practice Management Department in cooperation with the Department of Scientific Assembly.

* * * *

The Gallup Poll recently asked a sample to rate the honesty and ethical standards of several professions and other occupations. Physicians were given the highest marks, with 55% of those interviewed rating medical ethics and honesty as "very high" or "high." Engineers were second at 48%, and the legal profession came in fifth at 25%. Union leaders and advertising executives came out on the short end with 13% and 11%, respectively.

* * * *

AMA says it has made "prompt and responsible disclosure" during the Postal Service's recent inquiry into its second and third-class postal privileges. AMA Executive Vice President James E. Sammons, M.D., charged that some press accounts of the matter sounded "an echo of recent corporate cover-up stories." The Postal Service found that AMA meets criteria for the rates, Dr. Sammons observed, and no new information has surfaced that would change that.

* * * *

The Subcommittee on Health of the House Ways and Means Committee was scheduled to begin hearings on issues involved in increasing physicians' fees and possible revisions in Medicare's reasonable charge reimbursement system. Testimony was to center on factors that influence physicians to accept assignment or direct bill; factors contributing to geographical variations in doctor charges: differences in charges between primary care physicians and specialists; and related questions.

* * * *

Mrs. C. H. Gilliland of Gainesville has been appointed to the AMA Council on Scientific Affairs as a non-voting Auxiliary liaison member. Mrs. Gilliland was president of the FMA Woman's Auxiliary in 1969-70.

* * * *

The American Medical Association Education and Research Foundation guaranteed 2,864 medical student loans for $3.9 million during the first six months of this year. In the same period of 1975, only 1,816 loans were guaranteed, and the increase is attributed to rising tuition and decreased government support.

The Editor

"Approximately 95% of the [U.S.] children of ages 1-5 years had iron intakes below the standard"

U.S. Public Health Service (1974)

Where did that surprising statistic originate?

From the first survey designed to assess the nutritional status of the entire U.S. population. The conclusion above was the most striking result reported in the preliminary findings released in January 1974.

Were they really dealing with a true sample of the entire U.S. population?

Those conclusions were based on a sample of 10,126 people—a probability sample established by the U.S. Bureau of Census to reflect the country's total population, regardless of race or income.

Among those 95% with substandard iron intake, how low was their intake actually?

For whites and blacks, for both sexes, for both income levels, the mean intake of iron (as a percent of the standard) for the 1-5 year age group ranged from 60 to 69%. Typically, then, 95 children out of 100 have iron intakes that are only ⅔ of the standard.

Whose iron intake standard were they using?

The standard set by the Food and Nutrition Board of the National Academy of Sciences for this group.

Implication of all this?

That iron deficiency among preschoolers is anything but rare and signs like mental apathy, lethargy, irritability, behavior problems, may be telegraphing iron deficiency.

Suggesting iron supplementation?

Not necessarily. In many instances this situation can be corrected by proper diet and, obviously, this is the preferred route. When dietary improvement is not attainable, consider a supplement.

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Is this cited study generally available?

Yes, from the Office of Information, National Center for Health Statistics, 5600 Fishers Lane, Rockville, MD., 20852. Request "First Health and Nutrition Examination Survey", 1974, DHEW Pub. No. (HRA) 74-1219-1.

*B. Blackwell: The Drug Defaulter. *Clinical Pharmacology and Therapeutics* 13:841 (1972).

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Vitamin B-12	1.5 mcg.
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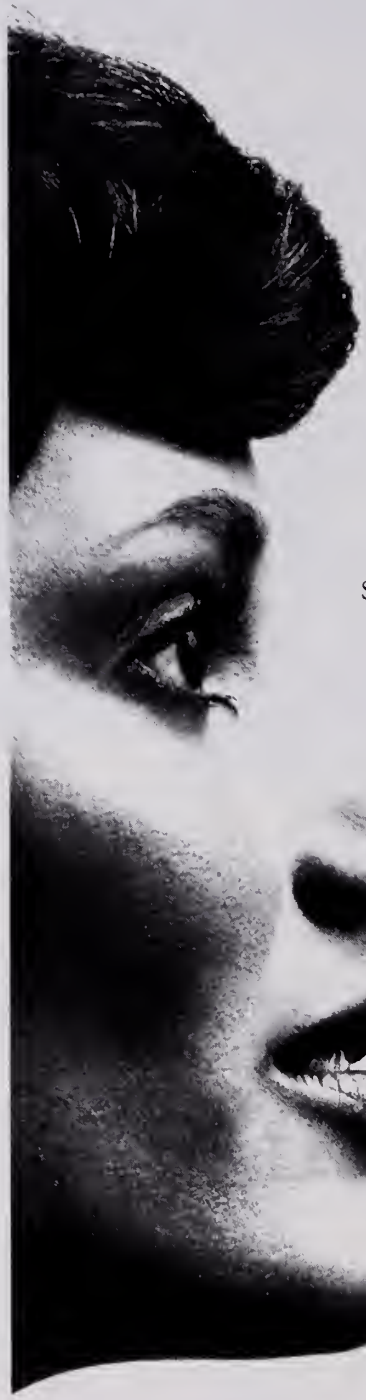
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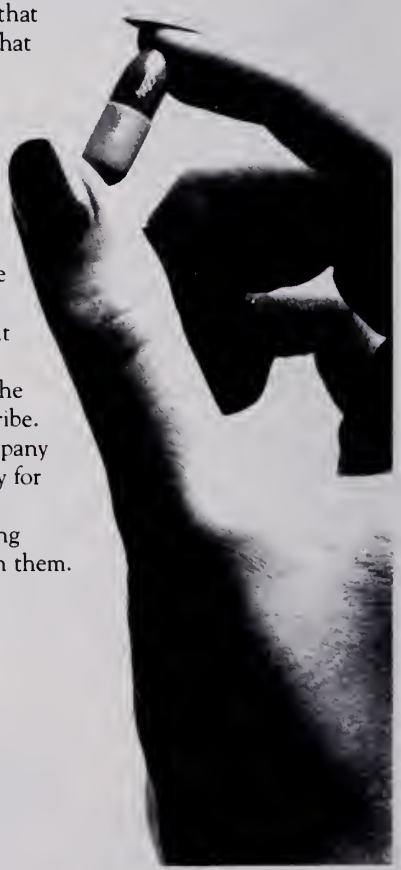
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC

SPECIAL ISSUE
NEUROLOGICAL SURGERY

Albert L. Rhoton Jr., M.D., Guest Editor

Introduction

The first neurosurgical practice in Florida was established 42 years ago and the Florida Neurosurgical Society was founded 18 years ago. The specialty has come a long way since these early days as described by Dr. James G. Lyerly Sr. in this issue of the Journal. Those engaged in its practice have progressed in knowledge and skills as have their colleagues throughout the country.

Currently in Florida there is one neurosurgeon per 100,000 people and in the United States one per 75,000 people, according to a Neurosurgical Manpower Commission report. Formerly a base population of 1 million people was believed necessary to support one neurosurgeon.

The Florida Neurosurgical Society's aim in presenting the material in this issue is to provide the opportunity for physicians to be more aware of advances in the diagnosis and treatment of conditions amenable to neurosurgical procedures as well as advances in available facilities. Strengthening of the postgraduate network has made these advances more rapidly available to patients.

The range of topics discussed in this issue is proof that we are a growing, progressive specialty.

The radical one-step correction of craniofacial abnormalities is a rapidly developing multispecialty program. It combines the skills of ENT, brain, plastic and eye surgeons. Microneurosurgery has improved the accuracy of older procedures, as in clipping intracranial aneurysms, and has led to development of new ones, as in the anastomosis of scalp to cerebral arteries to bypass cerebrovascular occlusion. This is illustrated in Dr. Rhoton's article.

Use of the microscope during removal of acoustic neuromas has enabled preservation of facial and cochlear nerves with increasing frequency. It also has allowed transsphenoidal exploration of the pituitary for removal of small adenomata in some hypersecretion syndromes, and for total hypophysectomy for hormone dependent malignancies.

Neurosurgeons continue to be exercised in treatment of intractable pain. A recent method is electrical stimulation of nerves to the painful area either by skin or implanted electrodes. Stereotactic percutaneous cordotomy continues to be a widely used procedure in controlling pain of malignant lesions. Percutaneous radiofrequency trigeminal nerve lesions are being used with increasing frequency to relieve tic douloureux. Complications and risk are far less than open craniotomy procedures performed in the past.

Treatment of head injuries continues to be surgical, where indicated, plus maintenance of good ventilation and judicious use of steroids and dehydrating agents. New devices for the constant



Thomas O. Brackett, M.D., President
Florida Neurosurgical Society

monitoring of intracranial pressure have allowed for better treatment and control of these patients.

Neurosurgical diagnosis has been revolutionized by introduction of computerized tomography. The technique permits visualization of intracranial structures without the hazards and discomforts of angiography and air studies, and with greater accuracy. Cerebral mass lesions and atrophy are readily diagnosed; the physician can differentiate between infarct and hematoma and even gauge the age of the hematoma.

Speaking for our colleagues, we are proud to present this review of our work and capabilities, and grateful to the editors of the Journal for the opportunity to do so.

Thomas O. Brackett, M.D.
President
Florida Neurosurgical Society
Robert S. Tolmach, M.D.
Past President
Albert L. Rhoton Jr., M.D.
Guest Editor

* * * *

To The Neurosurgeons of Florida: It is most gratifying to learn that the Florida Neurosurgical Society is preparing an issue of the Journal of the Florida Medical Association devoted to neurological surgery.

Over the years it has been obvious that the special treatment and care which neurological surgeons are prepared to offer to patients with neurological diseases can not be effective unless the primary physicians responsible for the patients are aware of what neurological surgery can do and of the importance of referring the patients early for neurosurgical treatment before permanent disability has developed. The neurological surgeons of Florida are to be congratulated upon having prepared this special issue to inform all members of the medical profession as to what neurological surgery can accomplish and as to the importance of providing neurosurgical care as early as possible.

Neurological surgery is a steadily expanding field. It is no longer confined to the treatment of tumors of the brain and spinal cord, although this is still important. Many tumors and malformations of the nervous system which were formerly inaccessible or which did not respond to treatment, can now be effectively treated, and in many cases eradicated. This is only possible when all of the medical profession are aware of the possibilities and of the importance of early diagnosis and treatment. Neurological surgery is still a rapidly expanding field both in the areas of diagnosis and of therapy.

This issue of the Journal of the Florida Medical Association is a commendable effort on the part of Florida neurosurgeons to inform others regarding recognition, diagnosis, and treatment of neurological diseases.

Paul C. Bucy, M.D., Editor
Surgical Neurology
Tryon, N.C.

* * * *

Congratulations to you, the Florida Neurosurgical Society and especially to the neurosurgeons from around the State who are participating in the preparation of the neurosurgical issue of the Journal of The Florida Medical Association. As far as I know this is the first time that this has been done. Again, congratulations on your pioneering efforts. I am sure that it will be most successful.

Lester A. Mount, M.D., President
American Association of
Neurological Surgeons
New York, N.Y.

* * * *

It is with great pleasure that I congratulate the Journal of the Florida Medical Association for the publication of this special edition devoted to the diagnosis and treatment of surgical diseases of the nervous system. To enhance the medical knowledge of the Association members is, I am sure, the principal aim of the Journal. That goal has been achieved by making available the most recent acceptable information in the field of neurological surgery. I would predict that better patient care will result from this publication. I commend my Florida colleagues for their desire to update the neurosurgical knowledge of the Florida physician and suggest a similar endeavor in other specialty areas.

Bruce F. Sorensen, M.D., President
Congress of Neurological Surgeons
Salt Lake City, Utah

* * * *

On behalf of the Southern Neurosurgical Society I would like to offer my congratulations to the Journal of the Florida Medical Association and the Florida Neurosurgical Society on the occasion of this neurosurgical issue. Through the combination of local, state, and regional efforts, we will continue, to the best of our abilities, to provide the best availability and delivery of information and medical care that exists.

Courtland H. Davis Jr., M.D., President
Southern Neurosurgical Society
Winston-Salem, N.C.

Pioneering in Neurological Surgery in Florida

James G. Lyerly Sr., M.D.

Abstract: Previous to 1934, there was no neurosurgeon in Florida, southern Georgia, or south of Richmond and Atlanta. It was thought that a neurosurgeon must attract patients from a million or more population to conduct a successful practice. The author located in Jacksonville to conduct a neurosurgical practice covering Florida and southern Georgia and the adjacent southeast area. It was necessary for him to furnish a full set of neurosurgical instruments and equipment for operations. It was also necessary to create an acquaintance of doctors by traveling out of town on consultations, meeting doctors, and giving talks at medical society meetings. Writing papers, and publishing them in medical journals, with reprints were required to increase acquaintance of doctors.

After World War II neurosurgeons started locating in the principal cities and medical centers of the state. In 1958, the Florida Neurosurgical Society was formed with 30 members. This number has increased and now there are approximately 100 members.

Historical Remarks on Neurosurgery

The father of neurological surgery always has been Harvey Cushing who went from Johns Hopkins Hospital in Baltimore to Peter Bent Brigham Hospital in Boston in 1913 to become chief of the department of surgery at Harvard University. Generally, neurosurgery was not recognized as a specialty until World War I when separate departments were established in the armed services hospitals. After World War I, specialists in neurological surgery were found in most of the leading medical schools. A special society called The Society of Neurological Surgeons was started around 1920 under the leadership of Harvey Cushing. Several outstanding neurological surgeons joined in the beginning, among them Harvey Cushing and Jason Mixter of Boston, Charles Elsberg and Byron Stookey of New York, Walter Dandy of Johns Hopkins, Charles Bagley of Baltimore, C. C. Coleman of Richmond, Charles Dowman, Sr. of Atlanta, and Ernest Sachs of St. Louis. There were also some neurosurgeons in the west and central part of the United States who joined the Society, but I will not mention them in this paper. The first neurological society limited its membership to 20. Meetings were held twice a year in a neurosurgical center with the host responsible for the program which included an operative clinic.

The younger men working as associates of older neurosurgeons were not admitted into the Society because of limited membership. In 1931 a small group of associates formed a second neurosurgical society called The Harvey Cushing Society. I was a charter member of this Society which consisted initially of 23 members. The first meeting was in the spring of 1932 at the Harvey Cushing Clinic, Peter Bent Brigham Hospital in Boston. Dr. Cushing conducted an operative clinic, removing an astroblastoma from the left frontal lobe of the brain. I, along with others in attendance, presented a paper on Intracranial Section of the Eighth Cranial Nerve for Meniere's Disease with Report of Cases.

The Harvey Cushing Society increased its membership taking in qualifying neurosurgeons and became known as The American Association of Neurological Surgeons. Membership today stands at ap-



James G. Lyerly Sr., M.D.

Dr. Lyerly, now retired, was the founder of the Lyerly Neurosurgical Group in Jacksonville.

proximately 1,900. Associate members include a few outstanding medical neurologists, neurophysiologists, anatomists, roentgenologists and neuro-ophthalmologists.

In January 1925, Dr. Ralph Green, a neurologist from Jacksonville, by invitation attended a Society of Neurological Surgeons meeting in Richmond, and asked that I consider locating in Florida. By this time I had four years of training and practice of neurological surgery with C. C. Coleman, professor of neurological surgery at the Medical College of Virginia in Richmond. I visited Florida in 1925 and contacted leading physicians, chiefly in Jacksonville and Tampa. I decided not to move at that time because Dr. Coleman made me an offer of a partnership arrangement to locate permanently in Richmond. Patients were attracted to Richmond from four states: Virginia, West Virginia, North and South Carolina. I was busy with private practice and teaching, being an assistant professor of neurological surgery at the medical school. I also became a Fellow of the American College of Surgeons in the Division of Neurosurgery in 1927. Since Dr. Coleman was frequently out of the city for various reasons, the work load for the assistant increased.

The business depression came in the early 1930s and income greatly diminished. Around 1933 it appeared that Richmond could not support two neurological surgeons, and it seemed advisable that the younger man should look for a new location. I visited Cincinnati, Ohio, which had no neurosurgeon. I contacted the professor of surgery at the medical school and consulted other physicians in the city, who offered their support for a neurological surgeon. Again I considered Florida and made another trip there in 1933. The nearest neurosurgeons to Florida who were charter members of the Harvey Cushing Society were Edgar Fincher, Atlanta, Gilbert Anderson, New Orleans, Eustace Semmes, Memphis, Glenn Spurling, Louisville and James G. Lyerly, Richmond.

Most neurosurgeons believed that a man should draw patients from a million population to establish a successful practice. Since Florida had a million and a half population and one could draw patients from another half million population in southern Georgia, northern Florida seemed a good location. Neurosurgical patients leaving the state going to a northern or midwestern center traveled through Jacksonville, the gateway to Florida. Since there was no neurosurgeon south of Richmond, or Atlanta, Jacksonville seemed to be a choice location.

In 1933 I took and passed the Florida State Board Medical Examination and my license was registered in Jacksonville at that time. It was not feasible to come until the fall of 1934. My arrival date was known by several physicians including Dr. Ralph Green who called every hotel in town that first night and located me at the Seminole. He had a comatose patient in the hospital and wanted my consultation. I saw the patient who had a chronic subdural hematoma and who required an immediate operation that night, with the patient making a good recovery. This helped me greatly in starting my neurosurgical practice.

From the beginning I was on the staff at the Duval Medical Center, the local county hospital which had an excellent staff of interns and residents. I was kept busy doing operations and conducting neurosurgical clinics. I accepted appointments on the staff of private hospitals at St. Vincent's, St. Luke's, Riverside and Brewster.

A number of patients of indigent nature were coming from all over the state and southern Georgia. Duval Medical Center was the only hospital to take charity patients, but they had to be residents of Duval County. There were no federal or state funds to pay for this service. Occasionally a civic club or church group would help out. St. Vincent's would usually take these charity patients which enabled me to develop a neurosurgical center with a trained staff at the hospital.

It should be mentioned that no hospital had sufficient equipment for doing neurosurgical operations. There was no electrosurgery, or cautery unit in the hospital or state. Special instruments for a single surgeon were rarely furnished. I put a four-gap Bovie cautery unit in St. Vincent's where I did most of my work. I also carried a four-gap portable unit for work in other hospitals and for use on trips out of the city. I had to furnish a full set of neurosurgical instruments. To mention a few there were special hemostats, tissue forceps, scissors, suture, needles, cranial drills, rongeurs, Gigli saws, laminectomy retractors, lighted retractors, suction tips, skull traction tongs, and many others. I brought spinal water manometers with me which were the first in the city or state. I had a headrest made by a mechanic which could be fastened on any operating table for cranial osteoplastic flaps, cerebellar explorations, and operating in the upright position.

Every hospital in the city required a surgeon to designate one or two assistants to help him in operations. This assistant would be a younger surgeon who was starting a practice and not too busy

with his own work. The assistant would be asked to look after the patients when I was out of the city. Sometimes an intern or resident on surgery could be obtained as a surgical assistant.

In time my neurosurgical practice increased, and a full-time associate was required. I asked Dr. Paul Bucy of Chicago to send me a man. He sent Tracy Haverfield, who came to Jacksonville in 1940 and practiced neurosurgery with me until 1942 when he went into the service during World War II. When he left the service in 1945, he was invited to return to Jacksonville but he went to Miami instead. He was the first neurosurgeon in Miami and the second in the state. Dr. Mason Trupp shortly thereafter located in Tampa, and he was the third neurosurgeon in the state.

In 1937 Dr. Ralph Stevens, chief physician at the Florida State Hospital, Chattahoochee, appointed me neurosurgical consultant on the staff at that institution. I made monthly trips there for the next 25 years. There were over 300 epileptics requiring neurological evaluations, and as many as six pneumoencephalograms would be done in one day. Operations for brain tumors, subdural hematomas, prefrontal lobotomies, and many others were done on these visits.

In order to increase acquaintance with doctors in Florida and southern Georgia announcement cards were sent out. Invitations to see patients of an emergency nature out of the city were usually accepted, which was an opportunity to meet doctors in the neighborhood as well as being of service to these patients. Sometimes operations of an emergency nature would be done. If the patient could travel, a transfer to Jacksonville would be arranged, since the operation and postoperative treatment could be carried out under better personal supervision. These consultations were carried out in most of the hospitals in Florida and southern Georgia. The trips would be made by automobile in most cases carrying a full set of neurosurgical equipment. Occasionally airplane trips could be made, especially to Miami, where commercial service was available. Private plane service was not suitable as a rule, nor quicker than automobile travel, especially under 250 miles.

Additional acquaintance of doctors was obtained by accepting invitations to give talks and papers in county medical societies throughout Florida and southern Georgia. Medical papers were published in medical journals and reprints made which would be mailed to doctors in the area desired. This continued until after World War II when the Postal Service discouraged it, and the Internal Revenue Service would not permit the expense as tax deductible.

After 1945 many neurosurgeons were leaving the armed services and looking for locations. Most of the neurosurgical centers had an established residency training program. Authorization was obtained from the American Medical Association and the American Board of Neurological Surgery for a residency training program by me at St. Vincent's Hospital with affiliation at Duval Medical Center. This was kept up for several years when it was discontinued in Jacksonville because of the increasing number of neurological surgeons turned out by larger neurosurgical centers. There was an increasing number of neurosurgeons in the state, and in 1958 I sponsored the formation of a Florida Neurosurgical Society, with a membership of 30 neurosurgeons. Now there are over 100 men in the state doing this work.

A final remark should be made about the fees charged in those early days. One third of the work was outright charity, a second third was part pay, and the last third usually paid the full fee. The usual charge for a neurological examination was $15-$25. For a major operation, as for a brain tumor, a fee of $300 was usually made. A laminectomy for a dislocated disc was usually done for $150. Since then all the fees have necessarily increased because of inflation and because of greater expense in doing business.

Neurosurgery has come a long way from the early 1920s when a careful history, neurological examination and skull x-rays were the only means of making a diagnosis and operating on a brain tumor. Then came ventriculography for brain tumor diagnosis, and pneumoencephalography for diagnosis of the epilepsies. Sympathectomy was started around 1924, the suction tip in 1926, electrosurgery in 1928, arteriography around 1926 with the use of Thorotrast which was later discarded because of unfavorable reaction. Later Diodrast and now Hypaque are the prevailing contrast media for arteriography. Since 1935 operations for dislocated lumbar discs and later cervical discs were done, which are frequent procedures today. A final remark about myelograhy using Lipiodol after 1928, and Pantopaque after 1945, making the diagnosis and surgical treatment of space-occupying intraspinal and some posterior fossa lesions, more accurate and effective in the operative treatment.

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Recent Advances in Diagnosis and Treatment of Primary Intracranial Tumors

Arthur L. Day, M.D.
and Francisco Garcia-Bengochea, M.D.

Abstract: Within recent years substantial progress has been made in diagnosis and treatment of central nervous system tumors. Computerized axial tomography (CAT) represents a major breakthrough in neuroradiologic diagnostic techniques, providing a three-dimensional view of intracranial structures. The use of the surgical microscope in conjunction with improved methods of brain relaxation has changed the approach and effectiveness of the surgery of many tumors. The therapy of malignant gliomas remains a challenge, but intense investigations are currently directed toward establishment of more effective treatment.

Primary central nervous system tumors account for 1.2% of all autopsied deaths and for 9% of all primary neoplasms. The vast majority (85%) of these tumors are intracranial in location. Because of the crippling dysfunctions caused by such lesions, many investigators have directed their attentions toward this complex problem.

Diagnosis of intracranial neoplasms has made major advances in recent years. Radioisotopic brain scanning provides a safe, noninvasive means of screening tumor suspects. Its relatively low cost and extensive distribution in most communities insure its continued usefulness in present-day practice. Angiography can now be employed with relative safety when the vascularity of a lesion must be studied. With refinement in catheter techniques and improvement in contrast materials, morbidity has been substantially reduced. New magnification techniques allow the surgeon a more detailed preoperative knowledge of potential vascular problems. Transcatheter embolization done at the time of angiography may significantly reduce operative blood loss and actually reduce the size of the tumor.

The use of water-soluble contrast materials instilled into the ventricular system at the time of ventriculography has enhanced the diagnosis of third ventricular and posterior fossa tumors, areas traditionally difficult to delineate (Fig. 1). Use of this technique can be done with minimal risks, outlines the ventricular system well, and considerably shortens the length of the diagnostic procedure.

The greatest diagnostic advancement is the development of computerized axial tomography (CAT scanner). Since its recent introduction three years ago, it has revolutionized neurologic diagnostics, and further progress along this line should occur shortly with the expected refinements in instrumentation and techniques. The CAT scan provides a three-dimensional view of the brain anatomy by exposing serial 1.5 or 2.5 cm horizontal tomographic sections. It can be performed with or without the intravenous administration of iodinated contrast material, which brings out or delineates the vascularity of the lesion. The CAT scan can be done with minimal inconvenience and trauma to the patient and carries only minimal risk of complications when contrast is used. Current efforts are being directed toward obtaining sections in the coronal plane, thus allowing better visualization of basal structures such as pituitary and clival lesions. The CAT scan works by demonstrating changes in density of intracranial constituents, thus allowing

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Fig. 1.—Water-soluble ventriculogram demonstrating posterior third ventricle and fourth ventricle. There is a large oval mass (arrows) projecting into caudal part of fourth ventricle. Surgery showed the mass to be ependymoma.

neoplasms of all varieties to be visualized. It may outline adjacent edema and cyst formation, and it offers some prediction of the type of pathology present (Fig. 2). Cerebral metastasis can be identified by its multiplicity with greater frequency than with radioisotopic brain scanning or angiography, and it thus minimizes surgery on patients with multiple clinically silent lesions. The CAT scan also allows differentiation of neoplasms from intracerebral hematomas with previously unobtainable accuracy (Fig. 3). The development of hydrocephalus can be easily identified, and the efficacy of treatment can be studied without the invasive pneumoencephalogram (Fig. 4). The treatment of trauma has also been aided by shortening the length of time between occurrence of the injury and evacuation of a surgically significant blood clot, and it is devoid of the compounding images referable to scalp injuries as seen with radioisotopic scanning.

Surgery of intracranial tumors has been enhanced by the parallel advances in neuroanesthesia monitoring and vital systems control. The dreaded air embolism can be detected earlier, before the patient suffers irreparable insult. The judicious use of hypocarbia, ventilatory techniques, and certain anesthetic agents provides control of intracranial pressure without serious impairment of cerebral blood flow and tissue oxygenation of normal areas. Use of fluid mobilizing agents further relaxes the brain, minimizing retraction needed to visualize deeply placed lesions. Steroids, administered before, during, and after the operation, enable the brain to tolerate the procedure better and smooth the postoperative recovery phase.

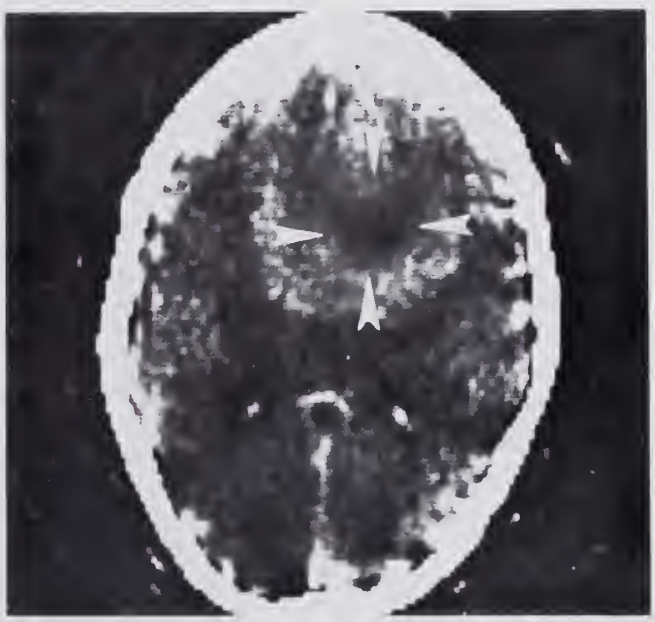


Fig. 2.—Noncontrasted scan demonstrating a large right frontal cystic mass (lucent area) (arrows) with surrounding bilateral frontal edema. At surgery, a malignant glioma was found.

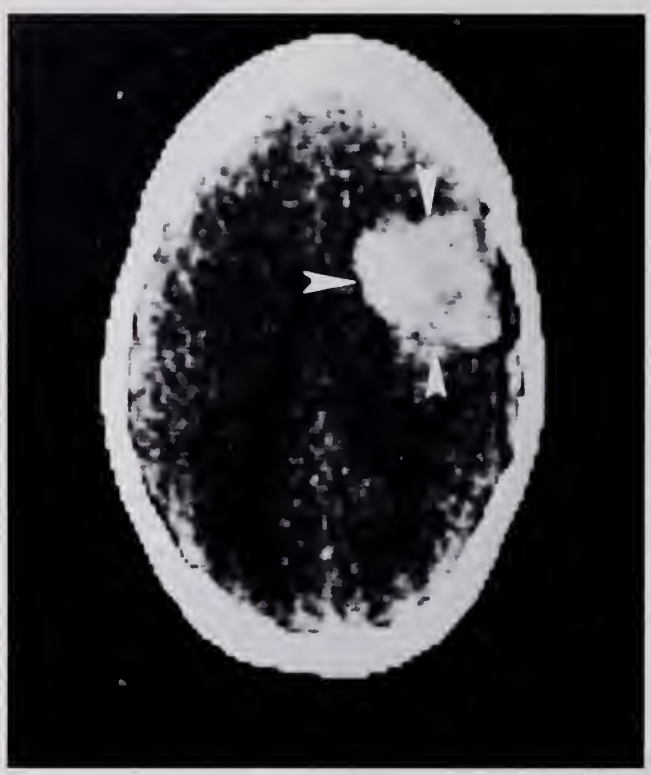


Fig. 3.—Noncontrasted CAT scan demonstrating dense right frontal mass (arrows). Diagnosis confirmed by surgery: intracerebral hemorrhage.

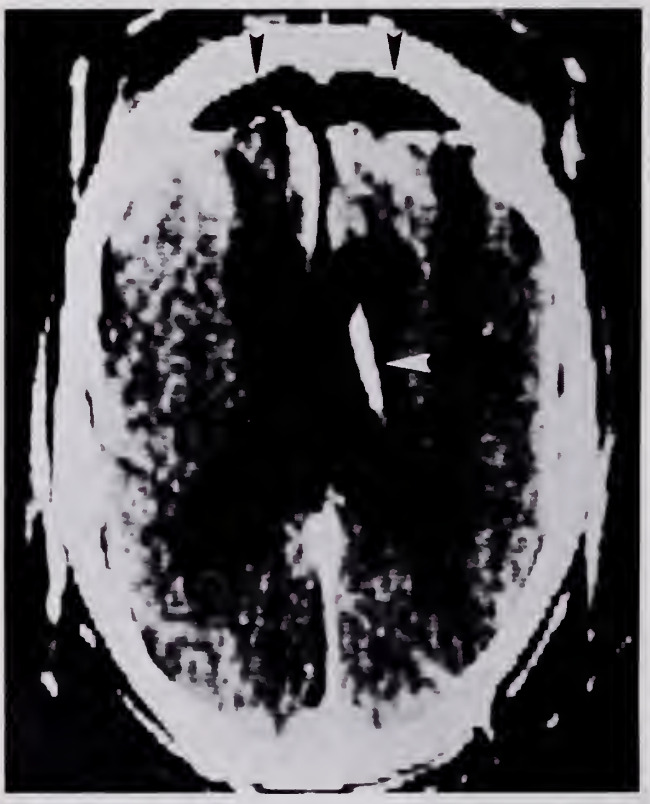


Fig. 4.—Contrasted CAT scan after placement of shunting system for hydrocephalus. Note position of shunt (horizontal arrow) and frontal radiolucent areas (vertical arrows) caused by collapse of ventricular system.

The addition of the binocular surgical microscope to the neurosurgeon's armamentarium has greatly facilitated the approach to and excision of certain neoplasms. Its use has heralded the return of the transsphenoidal route to the pituitary gland, both for tumors of that region and in hypophysectomy for hormonally dependent breast and prostate carcinomas. This approach, previously abandoned because of infection and poor visualization, can now be used with low morbidity and mortality, and its use has stimulated many new observations about pituitary disorders. The concept of the secreting pituitary microadenoma is now firmly established. These small tumors, causing only minimal or no sellar changes, many produce such entities as Cushing's disease, acromegaly, galactorrhea, or Nelson's syndrome. By using microsurgical techniques, it is possible to remove the entire adenoma and yet to spare the remaining normal gland. Investigators have outlined each type of microadenoma and its usual location within the gland.

The microscope, in conjunction with earlier otologic and radiographic diagnosis of smaller acoustic neuromas, allows the surgeon to approach the cerebellopontine angle more safely. By using the suboccipital transmeatal approach, it is occasionally possible to save some hearing. Complete removal of such tumors is more easily accomplished, with a higher probability of facial nerve preservation. Critical brain stem blood supply can be inspected and avoided.

Other than reduction of operative morbidity and mortality, surgery has done little in recent years to change the outlook for gliomas. This group of tumors constitutes 45% of all primary intracranial tumors, and it is now the subject of intense investigation. Surgery remains justified to establish the histological diagnosis, to reduce intracranial pressure, and to reduce the bulk of the tumor. Because of the limited surgical response in most cases, however, efforts are now directed toward development of a multimodal therapeutic approach involving surgery, radiation therapy, chemotherapy, and immunotherapy. Significant advances have already been achieved in treatment of some types of tumors.

Medulloblastoma, a highly malignant tumor of childhood, now carries a better prognosis, with some long-term survivals reported. With the addition of total spinal axis irradiation to surgery and operative site irradiation, ten-year survivals may reach 40%.

Evidence is accumulating that radiation of low-grade gliomas (astrocytomas, grades I and II) leads to significant, useful prolongation of life. The data suggest that all such gliomas, except possibly

those located in extreme polar regions or in the cerebellar hemispheres, or in which the surgeon felt total removal was achieved, should receive radiation therapy. The outlook for higher-grade astrocytomas (grades III and IV—glioblastomas) remains dismal. While radiation does add several months to life, long-term survival is poor.

Many investigations toward obtaining an agent that radiosensitizes tumor cells to the effects of radiation therapy have thus far been unimpressive. High-grade tumors usually contain large numbers of hypoxic but viable cells with large areas of necrosis. Such hypoxic cells are poorly responsive to treatment. Experimentally, by increasing oxygen content within these tissues either by breathing hyperbaric oxygen or by lowering metabolism with hypothermia, the tumor becomes more sensitive to irradiation. Such significant beneficial effects have not been reproducible clinically. Chemical radiosensitizers such as BUdR (5-bromodeoxyuridine) have also been used, but results are disappointing.

The use of chemotherapeutic agents in the combined treatment of brain tumors is being intensively pursued. Their efficacy in leukemia has already been established. The members of the nitrosoureas (BCNU, CCNU) appeared the most promising since these compounds are lipid-soluble and are capable of crossing the blood-brain barrier. Applied to malignant gliomas, however, they alone have not been shown to prolong survival appreciably. The best results have been achieved when BCNU is combined with surgery and radiotherapy. The apparent gains as measured in survival time are small, however, not greater than a few weeks, when compared with results from patients treated only with surgery and radiation.

Immunotherapy has not thus far been used with beneficial results in central nervous system tumors. Application of current immunotherapeutic techniques would appear to be a reasonable approach to these cancer patients, by augmenting their immune systems. As of yet, they have not yielded beneficial results in the treatment of central nervous system neoplasms and are not likely to be successful until better knowledge of the etiology and pathogenesis of these neoplasms is achieved.

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PAMPHLETS AVAILABLE FOR PATIENTS WITH NEUROLOGICAL DISORDERS

The National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) at the National Institutes of Health (NIH) has a "Hope Through Research" pamphlet series for patients. These are available upon request to physicians to offer to their patients. Each pamphlet describes a specific disorder in some detail and tells of research underway to prevent and treat it.

The pamphlets have been developed with the help of research scientists and clinicians at NIH and with the cooperation of professional societies. They are designed to be easily read and are conservative in approach.

Any or all of the pamphlets may be ordered for review. If a physician needs larger quantities, bulk orders will be filled without charge.

The subjects covered are: Amyotrophic Lateral Sclerosis; Acoustic Neuroma; Brain Tumors and Spinal Cord Tumors; Cerebral Palsy; Dizziness; Epilepsy*; Headache; Hearing Loss; Huntington's Disease (Huntington's Chorea); Learning Disabilities Due to Minimal Brain Dysfunction; Learning to Talk; Multiple Sclerosis; Muscular Dystrophy*; Myasthenia Gravis; Parkinson's Disease; Shingles (Herpes Zoster); Spina Bifida, a Birth Defect; Spinal Cord Injury; SSPE (Subacute Sclerosing Panencephalitis), and Stroke.

For copies write to the Office of Scientific and Health Reports, NINCDS, Building 31, Room 8A-06, NIH, Bethesda, Maryland 20014.

*Also in Spanish

Transsphenoidal Hypophysectomy in Metastatic Breast Cancer

Glenn Morrison, M.D.

Abstract: Up to 50% of women with metastatic breast cancer will show an objective response to endocrine manipulation. Newer laboratory methods may do much to further identify this population of responders. The pituitary gland influences not only the ovary and adrenal, but also breast tissue via prolactin. Prolactin may be important in the development of cancer. Pituitary function may be totally abolished by utilizing a transsphenoidal approach to remove the gland. This is a relatively safe and well tolerated procedure. A compilation of six reports (totaling 1,642 cases) gave an average remission rate of 56% (46%-81%). This procedure is not the answer for all women with metastatic breast cancer but may be quite helpful in the palliative management of some patients.

One in 20 women will develop carcinoma of the breast. Eighty eight thousand new cases will be seen in the United States in 1976.[1] Untreated, the five and ten year survival rates are 20% and 5% respectively.[2] With treatment 50% will survive five years and 20% ten years.[3] One third to one half of these tumors, in their disseminated or metastatic state, will be responsive to endocrine manipulation.

Oophorectomy has been widely employed in premenopausal women with metastatic breast cancer with good results (30%-40% remissions). When these women again have evidence of active disease or are postmenopausal at the time when first seen, then other forms of therapy must be considered. Radiotherapy has a real, though limited and local, role to play. The various chemotherapeutic regimes are gaining wider acceptance and, in general, good remission rates. However, these methods offer nonspecific, systemic, cytotoxic therapy, aimed at killing more "bad" (cancer) cells than "good" (host) cells. Endocrine manipulation offers more specificity and does not threaten other organ systems. It is fundamentally different in that it depends on the hormone sensitivity of the tumor.

Endocrine therapy can be either giving drugs to alter the normal relationships or performing ablative procedures such as hypophysectomy or adrenalectomy. Several series have reported similar remission rates with adrenalectomy and hypophysectomy,[4,5] although others have shown statistically significant differences in favor of hypophysectomy.[6] There are certain theoretical reasons why removing the pituitary gland may do more to alter the course of metastatic breast cancer then adrenalectomy. The pituitary controls ovarian and adrenal function and also directly effects the breast via prolactin. Prolactin has been implicated in breast cancer in various laboratory models and, although the role of prolactin in human breast cancer has not been established, it does appear to be potentially quite important.[7-9] L-dopa is occasionally helpful in painful bony metastases and this may be due to its known serum prolactin lowering effect. However, this only reduces prolactin and hypophysectomy is necessary to completely remove its influence.

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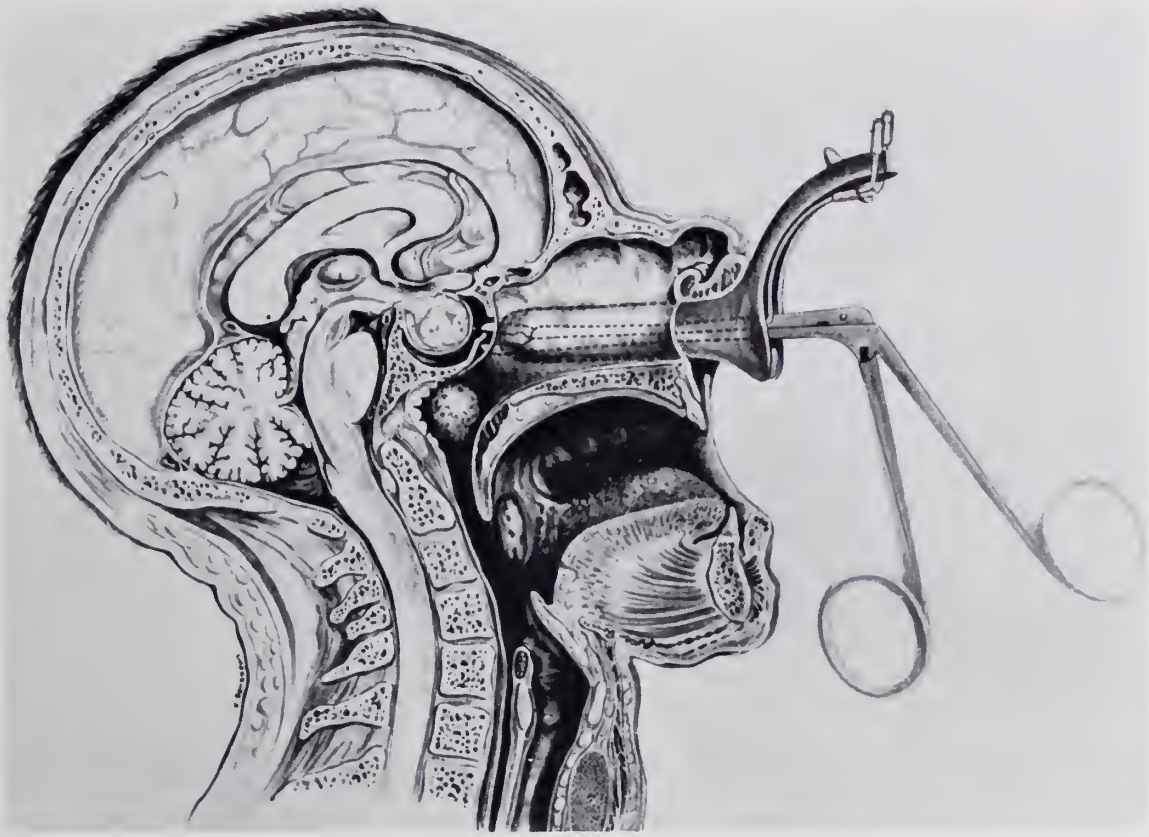


Fig. 1.—Scheme of transsphenoidal approach to the pituitary fossa.

The disease free interval and the response to oophorectomy may be important predictors as to the response to hypophysectomy. Also the quantitation of urinary steroids has been suggested as a predictor of response.[10] Now that estrogen binding sites have been identified in breast cancer tissue,[7,11] there seems good reason to believe that the response of a patient to endocrine therapy may be predicted by assaying for these hormone receptor sites in the primary or metastatic tumor tissue.

The pituitary gland lies within the sella turcica at the base of the skull and can be approached either through a craniotomy or a transsphenoidal approach. It is interesting to recall that Harvey Cushing initially performed three quarters of his pituitary operations via the transsphenoidal route only to abandon it in favor of the transfrontal approach. The frontal craniotomy with elevation of the frontal lobe, exposure of the optic apparatus and access to the pituitary fossa, became the standard operation until the relatively recent resurrection of the transsphenoidal approach. The use of the operating microscope with its illumination and magnification has made this procedure a relatively safe, well tolerated, extracranial procedure which involves no manipulation of intracranial structures and leaves no visible surgical scar.

Transsphenoidal hypophysectomy[12] (Fig. 1) involves a hidden sublabial mucosal incision, a submucosal resection of the nasal cartilage and easy access to the sella through the sphenoid sinus. Pituitary neoplasms, whether large, nonfunctioning chromophobes, or microadenomas that are endocrinologically active, are readily dealt with via this approach.[13-16] In metastatic cancer a total hypophysectomy may be important in order to get a remission. Use of the operating microscope affords a much better chance of this than does other, indirect, methods.

A compilation of six reports[6,17-21] of hypophysectomy in women with metastatic breast cancer, yielding a total of 1,642 cases, gives a mean remission rate of 56% (range 47% - 81%). The author was privileged to be associated with a series of 161 women with metastatic breast cancer in whom transsphenoidal hypophysectomy was carried out.[17]

This series had an objective remission rate of 47%. A remission was defined as objective regression of measurable tumors without the develop-

ment of new metastases lasting at least six months. Pain was relieved more often, but could not be quantitated and therefore symptomatic improvement was not included. Two thirds of the patients with remissions were still living an average of 21 months, whereas those not responding lived an average of only eight months.

Transsphenoidal hypophysectomy, as any surgical procedure, has some risks. Reported mortality rates have ranged between 1% and 4%. These mostly reflect patients dying within a month of surgery as a result of their disease and not the operation. All patients are on replacement cortisone and thyroid. Most show a transient diabetes insipidus which rarely requires continued treatment. Cerebral spinal fluid fistula occurs in 2% - 7% of patients and may require another operation to close the defect in order to prevent meningitis. Other rare (less than 1%) complications have been cranial nerve palsies, visual loss, and vascular injuries.

Hypophysectomy has a role to play in the management of metastatic breast cancer. Pituitary ablation via the transsphenoidal route offers many advantages over other methods and its specific, noncytotoxic character can offer a 47% - 81% remission rate. This is not a panacea, but one form of therapy that should be kept in mind by all physicians taking care of women with breast cancer.

References

1. Cancer, 26:22, 1976.
2. Bloom, H. J. G.: Survival of Women with Untreated Breast Cancer—Past and Present, in Forrest, A. P. M. and Kunkler, P. B., Eds., Prognostic Factors in Breast Cancer, Edinburgh, E. & S., Livingstone, 1968, pp. 3-19.
 Bloom, H. J. G.: The Natural History of Untreated Breast Cancer, Ann, N. Y. Acad. Sci. 114:747-754, 1964.
3. Westbrook, K. C.; Brown, B. W., and McBride, C. M.: Breast Cancer—A Critical Review of a Patient Sample with a Ten Year Followup, South. M. J. 68:543-548, 1975.
4. MacDonald, I.: Endocrine Ablation in Disseminated Mammary Carcinoma, Surg. Gyn. Obst. 115:215-222, 1962.
5. Joint Committee on Endocrine Ablative Procedures in Disseminated Mammary Carcinoma, JAMA 175:137, 787, 1961.
6. Atkins, H. J. B.; Falconer, M. A.; Hayward, J. L.; MacLean, K. S.; Schurr, P. H., and Armitage, P.: Adrenalectomy and Hypophysectomy for Advanced Cancer of the Breast, Lancet 1:1148-1153, 1960.
7. McGuire, W. L.: New Approach for Selecting Patients with Metastatic Breast Cancer for Hypophysectomy, Clin. Neurosurg. 21:39-59, 1974.
8. Sherman, L.: Prolactin and Breast Cancer, Cancer, 25:258-263, 1975.
9. Smithline, F.; Sherman, L., and Kolodny, H. D.: Prolactin and Breast Carcinoma. New England J. M., 292:784-792, 1975.
10. Bulbrook, R. D.; Greenwood, F. C., and Hayward, J. L.: Selection of Breast Cancer Patients for Adrenalectomy or Hypophysectomy by Determination of Urinary 17—Hydroxycorticosteroids and Etiocholanolone, Lancet 1:1154-1157, 1960.
11. Jensen, E. V.: Cancer Therapists Using Estrogen Receptor Test, JAMA 233:1255-1256, 1975.
12. Hardy, J.: Transsphenoidal Hypophysectomy, J. Neurosurg. 34: 582-594, 1971.
13. Rhoton, A. L.: Microsurgery of the Pituitary Gland, Med. Clin. N. A. 56:915-929, 1972.
14. Pearson, O. H.; Brodkey, J. S., and Kaufman, B.: Endocrine Evaluation and Indications for Surgery of Functional Pituitary Adenomas, Clin. Neurosurg. 21:26-38, 1974.
15. Atkinson, R. L.; Becker, D. P.; Martins, A. N.; Schaaf, M.; Dimond, R. C; Wartoksky, L., and Earll, J. M.: Acromegaly, Treatment by Transsphenoidal Microsurgery, JAMA 233:1279-1283, 1975.
16. Boyar, R. M.; Kapen, S.; Weitzman, E. D., and Hellman, L.: Pituitary Microadenoma and Hyperprolactinema, New England J. M. 294:263-265, 1975.
17. Brodkey, J. S., and Pearson, O. H.: Department of Neurosurgery and Medicine, Case Western Reserve University, School of Medicine, Cleveland, Ohio, 1974.
18. Collins, W. F.: Hypophysectomy: Historical and Personal Perspective, Clin. Neurosurg. 21:68-78. 1974.
19. Patterson. R. H. Jr.: Hypophysectomy: Transfrontal Technique and Results in the Management of Metastatic Cancer and Diabetic Retinopathy. Clin. Neurosurg. 21:60-67, 1974.
20. Ciric, I. S. and Tarkinston, J.: Transsphenoidal Microsurgery, Surg. Neurol. 2:207-212, 1974.
21. Vangilder, J. C., and Goldenbery, I. S.: Hypophysectomy in Metastatic Breast Cancer, Arch. Surg. 110:293-295, 1975.

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It is a wholesome and necessary thing for us to turn again to the earth and in the contemplation of her beauties to know the sense of wonder and humility.

Rachel Carson

Cerebral Aneurysm

Gaston J. Acosta-Rua, M.D., James G. Lyerly Sr., M.D., Edward J. Sullivan Jr., M.D., James G. Lyerly Jr., M.D. and Howard C. Chandler, M.D.

Abstract: The natural history, symptomatology diagnosis, and treatment of intracranial saccular aneurysm are described. Emphasis has been placed on the initial management by the primary physician after the diagnosis of a subarachnoid hemorrhage. The authors believe that surgery should be performed as soon as the condition of the patient warrants. The use of the operative microscope and microtechniques have diminished the mortality and morbidity in the treatment of intracranial aneurysms.

This article reviews intracranial aneurysms and subarachnoid hemorrhage for those physicians not specializing in neurological diseases. Intracranial aneurysm should be the major diagnostic consideration in the adult patient presenting with a subarachnoid hemorrhage.

History

The first description relating aneurysm and subarachnoid hemorrhage was by Osler[1] in 1877, but it was not until 1891 when Quincke[2] introduced the lumbar puncture that it was confirmed clinically.

A completely new era in diagnosis of cerebral aneurysms began in 1927 with the introduction of cerebral angiography by Egas Moniz.[3]

The first intracranial surgery for an aneurysm was by Dott[4] in 1930 who treated it by reinforcing the wall with muscle. The first clipping of the neck of an internal carotid aneurysm was performed in 1937 by Walter Dandy.[5]

Etiology

Locksley,[6] in describing the natural history of subarachnoid hemorrhage in the Cooperative Study of 5,431 cases, reported that 51% were secondary to intracranial aneurysms; 22% were of undetermined causes; 15% were of hypertensive and/or arteriosclerotic vascular diseases; 6% were secondary to arteriovenous malformations; and another 6% were miscellaneous or multiple causes. Miscellaneous causes include blood dyscrasias, pheochromocytoma, anticoagulants, primary or metastatic tumors and bacterial endocarditis. The mycotic aneurysm which is secondary to bacterial endocarditis is rare and usually located peripherally on the vascular tree.

Pathogenesis

The pathogenesis of the berry aneurysm is still a controversial issue, but the most acceptable theory is that there is a defect in the media at the bifurcation of cerebral blood vessels. It is considered that there are congenital and acquired factors. Media and intimal defects[7] are among the congenital causes and progressive elastica fragmentation, atheroma and hypertension among the acquired causes.

Incidence of Subarachnoid Hemorrhage

The most complete studies of the incidence of subarachnoid hemorrhage (SAH) were done by Pakarinen[8] who described that SAH is the cause of 1.2% of all deaths. It accounts for 9.2% of the deaths due to vascular disease of the nervous system, and the incidence of ruptured aneurysms among those under age 60 is approximately 9.6 per 100,000. If these figures of Finland were applied to the United States, it would suggest that approximately 40,000 patients per year will be afflicted with a SAH. SAH secondary to ruptured berry aneurysm has a slightly higher incidence after age 30, while

From the Lyerly Neurosurgical Group in Jacksonville.

arteriovenous malformations are the most common causes of SAH under age 20.

Signs and Symptoms

The most common symptom is a sudden, severe, localized or generalized headache, with a stiff neck and often low back pain and sciatica due to meningeal irritation.

Diplopia of a sudden onset due to an incomplete or complete third nerve palsy is common with an aneurysm of the internal carotid posterior communicating artery junction and less frequent with aneurysm of the bifurcation of the basilar artery. Vertigo suggests a posterior fossa aneurysm.

Recent onset of localized headache may be a warning sign of an expanding but unruptured aneurysm. Following headaches, the most common symptom of SAH is a sudden loss of consciousness in 20% to 30% of the cases. Fever, nausea, vomiting, and convulsions are also frequent.

The most common nerve palsy is the oculomotor and, when increased intracranial pressure is present, a bilateral sixth nerve paralysis is often seen.

Diagnosis

A lumbar puncture will confirm the presence of blood in the cerebrospinal fluid and if a traumatic tap is suspected immediate centrifugation of the fluid for supernatant xanthochromia will establish the diagnosis. Four hours may be required for the lumbar spinal fluid to become bloody. At times, when a spinal puncture is performed soon after the onset of symptoms, the fluid can be clear and confuse the diagnosis. The clearing of the spinal fluid of blood can take from less than ten to more than 20 days.[20] Skull X-rays may show calcification of the wall of a giant aneurysm and sellar enlargement suggesting a pituitary tumor.

An electrocardiogram may show flattening or even inversion of the T waves and can be confused with the diagnosis of coronary thrombosis. In such a situation, enzyme studies are helpful. Also, acute pulmonary edema may occur and may be misdiagnosed in an unconscious patient.

Electroencephalograms are of value in helping to decide on which side the rupture has occurred if bilateral aneurysms are found.

The most important diagnostic test is cerebral angiography. We recommend a complete cerebral angiography via right retrograde femoral artery catheterization as soon as possible after the diagnosis of SAH has been confirmed by spinal puncture.

In those cases where angiography has failed to show the cause of SAH, the studies are repeated one or two weeks after the initial study because spasm or clot may obscure the aneurysm on the initial study.

Prognosis

The mortality rate of ruptured aneurysm is between 60% and 70%. Approximately 25% of the patients die in the first hemorrhage. The mortality rate is much less if no aneurysm or source of bleeding is found. The prognosis of multiple aneurysms, present in 15%-20% of those patients with SAH, is less favorable than for a single aneurysm.

The most common locations of aneurysm order of frequency is on the internal carotid; anterior cerebral and anterior communicating, and middle cerebral arteries.[6] The majority of the internal carotid aneurysms occur at the junction of the internal carotid with the posterior communicating artery. Approximately 15% of the aneurysms are in the posterior circulation. Aneurysms of less than 3 millimeters in diameter are unlikely to produce symptoms,[10] while those from 7 to 10 millimeters in diameter rupture and are considered to be of critical size for the production of symptoms.

Grading of the Patients

Botterell[11] introduced the standard method of grading aneurysmal cases:

Grade I—Minimal bleed: The patient is alert with no neurological deficit.

Grade II—Mild bleed: The patient is alert with minimal neurological deficits such as third nerve palsy, stiff neck.

Grade III—Moderate bleed: The patient is drowsy or confused with a stiff neck, with or without neurological deficit.

Grade IV—Moderate or severe bleed: The patient is stuporous, with or without neurological deficit.

Grade V—Severe bleed: The patient is in coma and with decerebrate movements.

An additional grade should be given for patients over age 50 and still another grade if the patient has a major heart, lung, kidney, or liver disease.

Treatment

After the subarachnoid hemorrhage has been confirmed by lumbar puncture, the patient should be immediately transported to a neurosurgical unit. The patient is kept on complete bed rest with neuro-

logical and vital signs monitored on a frequent basis. The bowels should be regulated by means of stool softeners or laxatives, but never enemas.

Once the aneurysm is confirmed by cerebral angiography, the patient is immediately started on antihypertensive therapy to try to lower the systolic blood pressure level from 10% for the normotensive patient to 25% for those with blood pressure greater than 175 millimeters.

Epsilon-aminocaproic acid is started with an initial loading dose of 5 grams followed by 24 grams a day in divided doses, in order to maintain an effective local level of antifibrinolytic activity.

Agitation is controlled with a tranquilizer or a sedative such as phenobarbital because of its anticonvulsant activity.

The natural history of a ruptured intracranial aneurysm is of such poor prognosis that operative treatment must be considered in practically every case. The operative management can be of an indirect approach such as a carotid ligation in cases of aneurysms of the anterior circulation or by direct intracranial approach by ligation or clipping of the neck of the aneurysm.

Encasement of the sac with surgical gauze or plastic may be necessary in certain cases but is not the ideal treatment. With the use of the operative microscope and microtechniques, the operative mortality and morbidity have been considerably decreased, especially in the good risk patients who are Grade I and Grade II of the Botterell classification. The results of the operative treatment are far superior to those of conservative management.

In our practice, 127 consecutive cases have been operated with the use of the microtechnique in the last four years, and we have used the "pterional approach" described by Yasargil[12] and others.

The treatment of intracranial aneurysm requires team effort by neurosurgeons, neurologists, internists, anesthesiologists, and respiratory therapists, in which each discipline plays an important role in the treatment of this challenging disease.

References

1. Osler, W.: Aneurysm at Second Bifurcation of Right Middle Cerebral Artery, Path. Rep. Montreal General Hospital 1:30-32, 1876.
2. Quincke, H.: Die lumbalpunction des hydroscephalus, Berl. Klin. Wichr. 28:929-933, 1891.
3. Moniz, E.: L-encephalographie Arterielle, Rev. Neurol. 48:72-90. 1927.
4. Dott, N. M.: Intracranial Aneurysm—Surgical Treatment, Trans. Med. Chir. Soc., Edinb. 47:219-240, 1932.
5. Dandy, W. E.: Intracranial Aneurysm of Internal Carotid Artery Cured by Operation, Ann. Surg. 107:654-659, 1938.
6. Locksley, H. B.; Sahs, A. L.; Perret, G. E., and Nishioka, H., (eds): Intracranial Aneurysms and Subarachnoid Hemorrhage: Cooperative Study, Philadelphia, J. B. Lippincott Co., 1969.
7. Glynn, L. E.: Medial Defects in Circle of Willis and Their Relation to Aneurysm Formation, J. Path. Bact. 51:213-222, 1940.
8. Pakarinen, S.: Incidence, Etiology and Prognosis of Primary Subarachnoid Haemorrhage, Acta. Neurol. Scand. suppl. 29: 1-128, 1967.
9. Tourtelotte, W. W. et al: Spontaneous Subarachnoid Haemorrhage, Neurology (Mivneap) 14:301-306, 1964.
10. McCormick, W. F. and Acosta-Rua, G. J.: Size of Intracranial Saccular Aneurysm, An Autopsy Study, J. Neurosurg. 33:422-427, 1970.
11. Botterell, E. H.; Lougheed, W. M.; Morley, T. P., and Vandewater, S. L.: Hypothermia in Surgical Treatment of Ruptured Intracranial Aneurysm, J. Neurosurg. 15:4-18, 1958.
12. Yasargil, M. G.: Microsurgery Applied to Neurosurgery, New York, Academic Press.

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At the close of life the question will be not,
How much have you got, but how much have you given;
Not how much have you won, but how much have you done,
Not how much have you saved, but how much have you sacrificed,
How much have you loved and served, not how much were you honored.

Nathan C. Schaeffer

Microsurgical Treatment of Neurovascular Disease

Albert L. Rhoton Jr., M.D.

ABSTRACT: Microvascular surgical techniques have improved the quality of the surgical treatment of occlusive cerebrovascular disease, intracranial aneurysms and spinal and cerebral vascular malformations. This article reviews current thinking about the microsurgical treatment of these disorders.

Microsurgery is defined as surgery done using the 3-40X magnification provided by the surgical microscope. A recent study of surgical services in the United States by the American College of Surgeons rated the application of microsurgical techniques to a treatment of vascular disease of the nervous system as one of the most significant advances in surgery during the period of 1945-1970.[1] The neurovascular disorders to which microsurgery is most commonly applied are intracranial aneurysms, arteriovenous malformations and occlusive cerebrovascular disease, and spinal vascular malformations. The following is a review of current thought on these vascular disorders.

Intracranial Aneurysms

The first report of the use of the microscope in treatment of intracranial aneurysms appeared in 1966.[2] Since then it has been shown that the mortality in aneurysm surgery using microtechnique can be reduced to 2%-3% in carefully selected groups of patients.[3,4] Signs, symptoms and therapeutic plan are reviewed in this issue in the article entitled "Cerebral Aneurysm" by the Lyerly Neurosurgical Group of Jacksonville.

Almost all ruptured intracranial aneurysms are amenable to intracranial ligation by microsurgical technique (Fig. 1). Many aneurysms, which due to their size, location and configuration were previously inoperable, have become operable with the advent of microtechnique. Microsurgery has made the need to ligate the carotid artery in the neck less common except in some giant aneurysms and aneurysms within the cavernous sinus. Microtechnique has improved the results in aneurysm surgery because surgical magnification permits more accurate identification of aneurysmal anatomy, perianeurysmal perforating arteries, weak spots in the aneurysm, small bleeding points, and variations in the circle of Willis. It permits the surgery to be done through a smaller cranial opening and minimizes the need for brain retraction.

Intracranial Arteriovenous Malformations

Intracranial arteriovenous malformations cause seizures and neural deficit by expansion, shunting blood away from the brain, and hemorrhage. The treatment of choice is total excision when possible as dictated by the lesion's location and size (Fig. 1). Conservative measures in general are ineffective and previous experiences have demonstrated the the futility of carotid ligation, decompression and clipping of feeding arteries in long term treatment.[5,6] Many intracranial arteriovenous malformations were considered unsuited for operation before introduction of the surgical microscope and even with the broadened indications for operations some lesions cannot be extirpated with acceptable risk to life and function.

The malformations considered for surgery usually present with bleeding, seizures or progressive neurological deficit caused by ischemia due to shunting of intracranial blood. Indications for surgery include repeated subarachnoid hemorrhage, intracerebral hemorrhage and progressive neurological deficit. Malformations causing seizures should be excised if they are favorably situated in a location where the risk of producing a major functional deficit is not great. Small malformations associated with prior bleeding may be excised even if they are in important functional areas; however, large or deep malformations in important functional areas should be treated without surgery.

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Fig. 1.—Pre- and postoperative angiogram of patient with right middle cerebral artery aneurysm and right frontal arteriovenous malformation.
A. Right carotid angiogram before surgery showing middle cerebral artery aneurysm (horizontal arrow) and frontal arteriovenous malformation (vertical arrow).



B. Postoperative angiogram showing obliteration of arteriovenous malformation and cerebral aneurysm. The clinical result was good.

The same supportive measures applicable to ruptured aneurysms are applicable to arteriovenous malformations; however, there is not the same sense of urgency to perform early surgery on AVMs as there is on arterial aneurysms because the risk of early rebleeding is small. Emergency surgery is done only if there appears to be a life threatening hematoma. The goal is total excision whenever possible. The initial surgical attack should be directed to the major arterial feeding vessels, although that is not always necessary and at times impossible to accomplish. Feeding or draining vessels are traced to the edge of the malformation and an excision done using bipolar coagulation and straight clips. An attempt should be made to preserve all adjacent vessels. Intraoperative and postoperative adjuncts are the same as used in aneurysm surgery.

Arteriovenous Malformations of Spinal Cord

Microsurgical technique has reduced the hazards of surgery of arteriovenous malformations of the spinal cord and led to excision as the treatment of choice. Early diagnosis and surgery is important because once a deficit has developed it rarely improves but is slowly or rapidly progressive, frequently in a stepwise fashion. Far advanced disabling deficits prior to surgery infrequently improve after surgery although the author has seen patients, confined to a wheelchair, walk again.

Consider the diagnosis of a spinal AVM if no cause is found for a spinal cord deficit, if no intracranial cause is found for a subarachnoid hemorrhage, or if a spinal cord deficit is associated with a subarachnoid hemorrhage. Any patient with a spinal cord deficit having a negative myelogram in the prone position should be turned to the supine position for myelography because these lesions are most commonly on the dorsal surface of the cord. They frequently will not be seen on a myelogram done in the prone position.

Spinal cord angiography is essential in the evaluation of these patients although the results of the angiography may be misleading. Large feeding vessels not revealed by angiography have frequently been seen at surgery.

The author's initial surgical procedures involved in a long laminectomy, often five to eight segments, covering the full length of the malformation including venous drainage; however, with increasing angiographic and surgical experience, it has often been possible to define a vascular nidis which could be exposed and excised through a two or three level laminectomy. Once exposed the bi-

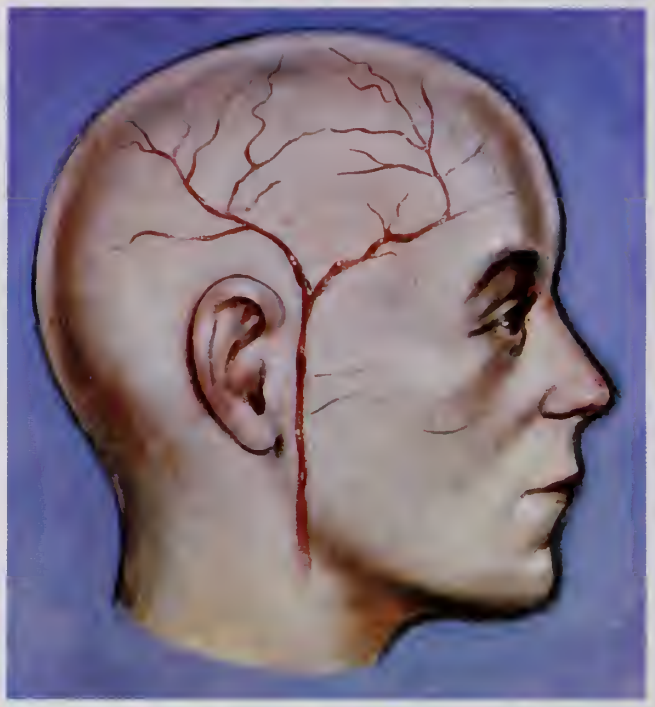
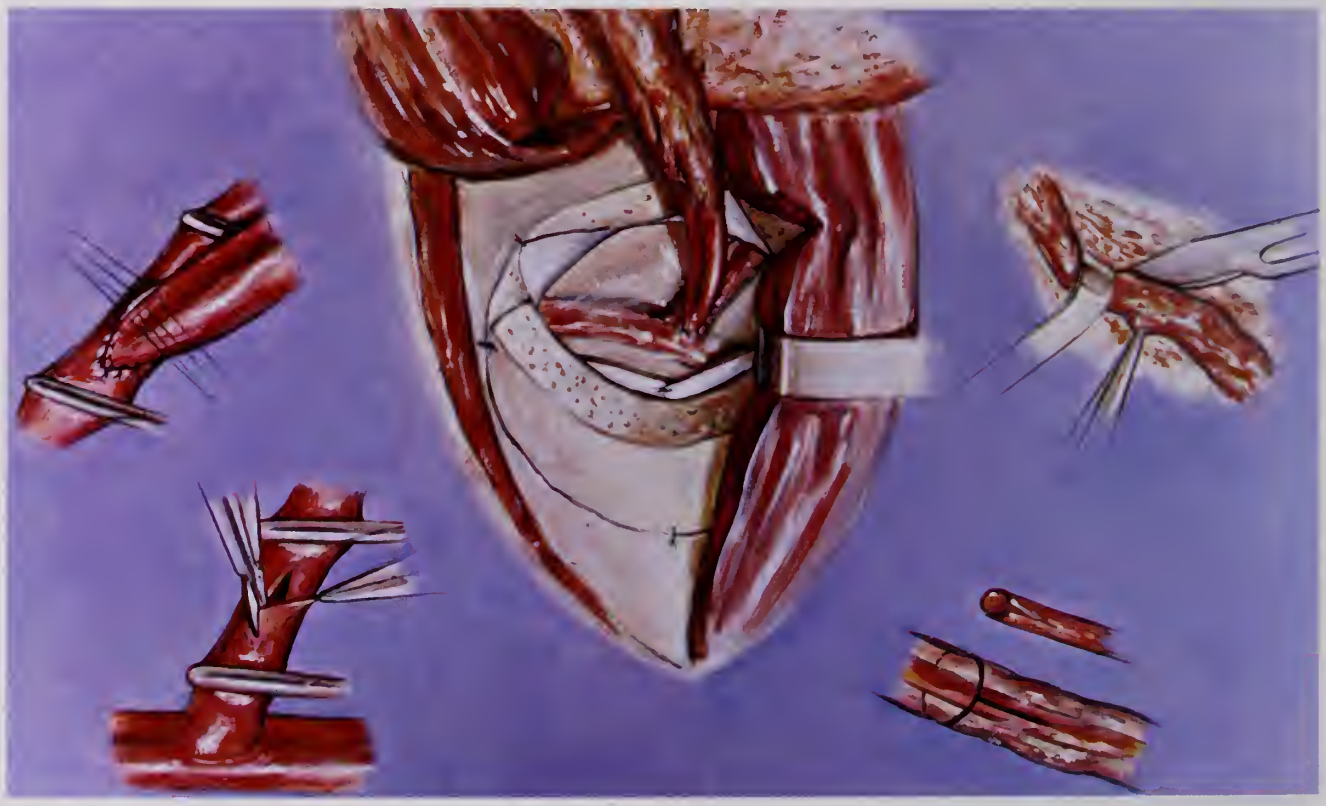




Fig. 2.—Steps in completing right superficial temporal to middle cerebral artery anastomosis.
A. Superficial temporal branch used for graft courses anterior to ear.

B. Scalp and muscle flaps turned, craniectomy completed and dura opened. The muscle flap is notched to prevent constriction of the temporal artery graft as the muscle is closed.



C. Center: Anastomosis completed and dura and bone closed so as not to constrict the graft. Muscle flap notched where graft penetrates it. Lower left: Temporal artery is dissected from the scalp flap through the base of the hair follicles. Periarterial fat left attached to the temporal artery to preserve the vasavasorum of the artery. Upper left: The end of the temporal graft is prepared for the anastomosis. Upper right: Ellipse is removed from the middle cerebral branch in preparation for the anastomosis. Lower right: The sutures at both ends of the ellipse are placed initially. All the sutures along one side of the graft are placed, then tied, and then the other side is completed.



Fig. 3.—Pre- and postoperative angiogram of the patient with an internal carotid artery occlusion.
A. Lateral view: The internal carotid artery is obstructed with poor filling into the carotid syphon (arrow) through collateral vessels.



B. Postoperative lateral angiogram with selective injection of the external carotid artery shows excellent filling into the area of the middle cerebral distribution through the superficial temporal (arrow) to middle cerebral artery anastomosis.



Fig. 4.—A. Lateral angiogram of patient showing high grade carotid stenosis (arrow) suggestive of a carotid occlusion.



B. Angiography delayed for several seconds after injection. A small string of contrast material passed up to the carotid syphon (arrows) indicating that the internal carotid is open and that the patient is a suitable candidate for carotid endarterectomy.

polar coagulation forceps with fine tips are used to coagulate small vascular connections with the cord surface and the malformation is separated from the spinal cord surface with microscissors. Most malformations can be removed without entering the spinal cord, but some require splitting the dorsal surface to identify feeding vessels coming from the sulcal branches of the anterior spinal artery. One patient having a malformation in the central part of the upper cervical cord was operated on awake, but with an endotracheal tube in place, so that motor function could be tested after each of five feeding vessels were occluded. After occlusion of all of the major feeding vessels was accomplished without deficit the patient was anesthetized and the malformation removed.

Approximately 15% of patients have some increased deficit with surgery; however, this should be weighed against the natural history of the disease which indicates that the average patient becomes wheelchair ridden two years after the first symptoms appear.[7]

Occlusive Cerebrovascular Disease

Microsurgery has made it possible to anastomose arteries of the scalp such as the superficial temporal and occipital arteries directly to branches of the middle cerebral arteries in patients with TIAs or mild completed strokes having occlusions in arteries inaccessible or inoperable by general vascular techniques (Fig. 2). In the National Cooperative Study on extracranial arterial occlusion, arteriographic investigation revealed 20% of patients demonstrated "inoperable or inaccessible lesions" by conventional surgical techniques.[8] The outlook with such lesions is poor. The first superficial temporal to middle cerebral artery bypass was done in 1967 on a patient with bilateral internal carotid and unilateral vertebral artery obstruction with disabling TIAs.[9] Five years later the anastomosis was patent and the patient was doing well.[10] Lesions amenable to such treatment are occlusion of the internal or common carotid artery in the neck, and occlusion or stenosis of the middle cerebral or intracranial carotid artery. Recently the procedure has been extended to the vertebrobasilar circulation where anastomosis between the occipital and the posterior inferior cerebellar artery have been done; however, the experience with this is limited as compared to that obtained with superficial temporal to middle cerebral anastomosis. The majority of patients having the procedure because of transient cerebral ischemic episodes have been relieved.[11-13]

The incidence of permanent neurological complications has been less than 5% and the majority of patients with TIAs have had an improvement in symptoms.[11-13] Average flow through the anastomosis has been approximately 70 cc per minute, but flows over 150 cc have been reported.[13] Over 80% of the anastomoses between the superficial temporal and middle cerebral arteries have been open at postoperative angiography (Fig. 3.).

The contraindications to the procedure are severe long-standing neurologic deficit, marked hypertension with small vessel disease on angiography, severe cardiovascular disease, severe diabetes with diffuse peripheral vascular disease and inadequate diameter of the donor scalp artery (smaller than 1 mm). The author prefers to delay surgery for six weeks after an episode of cerebral infarction.

One should scrutinize the angiogram carefully before concluding that a carotid artery is occluded and a STA-MCA anastomosis is done. The author has seen several cases referred for STA-MCA anastomosis because of a carotid occlusion in which an almost imperceptible amount of contrast media passed through a high grade stenosis at the internal carotid origin. In these cases routine carotid endarterectomy led to flow restoration to the brain. (Fig. 4).

References

1. American College of Surgeons and American Surgical Association. Surgery in United States, 1975, p. 155.
2. Pool, J. L. and Colton R. P.: Dissecting Microscope for Intracranial Vascular Surgery, J. Neurosurg. 25:315-318, 1966.
3. Lougheed, W. M. and Marshall, B. M.: Management of Aneurysms of Anterior Circulation by Intracranial Procedures. In Youmans, J. R. (ed): Neurological Surgery. Philadelphia, W. B. Saunders Co., 1973, vol. 2, pp. 731-767.
4. Yasargil, M. G. and Fox, J. L.: Microsurgical Approach to Intracranial Aneurysms, Surg. Neurol. 3:7-14, 1975.
5. Morello, G. and Borghi, G. P.: Cerebral Angiomas, Acta Neurochir. 28:135-155, 1973.
6. Olivecrona, H. and Riives, J.: Arteriovenous Malformation of Brain, Arch. Neurol. Psychiat. 59:567-602, 1948.
7. Newman, M. J. D.: Racemose Angioma of Spinal Cord, Quart. J. Med. 28:97, 1959.
8. Hass, W. K.; Fields, W. S., and North, R. R., et al: Joint Study of Extracranial Arterial Occlusion—II. Arteriography, Techniques, Sites and Complications, JAMA 203:961-968, 1968.
9. Yasargil, M. G.; Krayenbuhl, J. A., and Jacobsen II, J. H.: Microneurosurgical Arterial Reconstruction, Surgery 67:221-223, 1970.
10. Chater, N. and Yasargil, M. G.: Results of Temporal Artery Bypass Procedures in Treatment of Cerebrovascular Disease. Presented at Congress of Neurological Surgeons meeting, Miami, October 1971.
11. Chater, N.; Reichman, H., and Tew, J.: Cerebral Revascularization for Occlusive Cerebrovascular Disease. Presented at meeting of American Association of Neurological Surgeons, Los Angeles, April 8-11, 1973.
12. Chater, N.; Weinstein, P., and Peters, N.: Neurosurgical Microvascular Bypass for Stroke. Current Status Scientific Exhibit, American College of Surgeons meeting, San Francisco, October 1975.
13. Reichman, O. H.: Extracranial-Intracranial Arterial Anastomosis for Occlusive Cerebral Ischemia. Presented at American College of Surgeons Post Graduate Course, San Francisco 1975.

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Surgical Therapy of Epilepsy

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Abstract: Neurosurgical treatment of the epilepsies should be considered if the patient is disabled from seizures of focal onset that cannot be controlled by maximal, nondisabling medicinal therapy and if the epileptogenic lesion is localized within an area of dispensable cortex. The surgical therapy of epilepsy requires specialized facilities and skills and a team effort, beginning with the initial evaluation and continuing through the patient's recovery and rehabilitation. The main purpose of neurosurgical management is to reduce the seizure tendency. With some limitations, approximately one third of all patients will be totally free of seizures after operation, and an additional one third will have a marked (worthwhile) reduction of seizure tendency. In the remaining one third, or less successful cases, a slight to moderate reduction in seizure tendency occurs. Hence, neurosurgical therapy of the intractable epilepsies can bring substantial benefit to carefully selected patients who are desperately in need of symptomatic relief or definitive therapy.

The patient with epilepsy has a serious malady. His recurring symptoms are frequently disabling or life-threatening unless they are controlled or eradicated. Fortunately, the majority of patients with seizure disorders can be treated with anticonvulsant medication with highly satisfactory results. However, there are many patients with intractable seizure disorders who resist any attempts at medical management. Furthermore, the drugs required to control the seizures, particularly with excessive use, may have serious side effects such as lethargy, psychic deterioration, degeneration of neurons, ataxia, aplastic anemia, and liver toxicity. Patients with epilepsy often have severe psychosocial and economic handicaps. Hence, the patient with an intractable seizure disorder is desperately in need of symptomatic relief or definitive therapy. The physician caring for such patients should be aware that excellent results can be achieved in certain patients who are carefully selected for neurosurgical management.

Epilepsy is a symptom having many varied causes and is not itself a disease. Since a space-occupying structural lesion such as brain tumor, arteriovenous malformation, brain abscess, or intracranial hematoma frequently causes seizure disorders, it is imperative that a careful investigation for such lesions is accomplished before a diagnosis of idiopathic epilepsy is entertained. Furthermore, it may be necessary to repeat such investigations from time to time thereafter. Those patients with space-occupying lesions, once discovered, should be immediately considered for neurosurgical care. Patients who have a static cerebral lesion (often a focal atrophic process secondary to trauma, inflammation, intracerebral hemorrhage, or anoxia) should be allowed a trial of anticonvulsant medication before neurosurgical management is contemplated. It is these latter patients who present with a seizure disorder of cerebral origin and in whom adequate anticonvulsant medication has brought less-than-satisfactory control who are the concern of this article.

The prevalence of epilepsy in the United States is approximately 5 per 1,000, and there are currently in excess of 1 million patients with epilepsy. A conservative estimate is that 20% of these patients are intractable (not controlled with medical therapy) and 10% would benefit from neurosurgical therapy.[1] Thus, there are in excess of 100,000 patients with epilepsy in the U.S. who would benefit from neurosurgical management. The investigation and treatment of such patients is expensive, very time-consuming, and requires a comprehensive program which includes the availability of a surgical team specifically experienced in the specialized techniques of epilepsy surgery. The team effort involves the close collaboration of neurosurgeons, neurologists, and electroencephalographers who have a broad experience in all aspects of epilepsy, both clinical and experimental. The guidance of the neuroradiologists and neuropsychologists and the assistance of specially trained staff nurses, social workers,

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psychiatrists, and rehabilitation medicine personnel are important to the team effort. Without such a comprehensive program, the neurosurgical management of the epilepsies is frequently not successful.

The neurosurgical treatment of the epilepsies is based on the concept that seizures originate from "local discharges in gray matter."[1] The outstanding investigations of Penfield and his associates[2] on the localization of cerebral function as well as the development and refinement of electroencephalography and neuroradiological contrast procedures have contributed substantially to the creation of an effective system of investigation and operative therapy of the epilepsies. The modern surgical management is based on the principle of surgical excision of a chronic and reasonably well-circumscribed focal epileptogenic lesion from the brain in order to reduce or eliminate the patient's seizure tendency.[3]

Selection of Patients

Without question, the proper investigation and selection of patients for the neurosurgical therapy of epilepsy is the single most important factor which determines the success or failure of this form of treatment. The primary criteria for selection are: (1) continuing serious disability from seizure in spite of adequate, nondisabling amounts of anticonvulsant medications, (2) consistent clinical and laboratory evidence that the epileptogenic lesion is well-circumscribed (focal), and (3) the epileptogenic lesion in an accessible area of brain which can be excised without causing a significant neurological disability and without increasing one already present. Of course, these criteria must be individually tailored to each patient.

The first consideration in selection of patients for neurosurgical management is to collect all available evidence which will establish the focal nature of the epileptogenic lesion. A decision regarding the focal nature of the lesion is made only after careful evaluation of the history, seizure pattern, results of the neurological examination, recordings of cerebral electrical activity, and results of neuroradiological studies.

Not infrequently the clinical history is the key to determining the etiology and the localization of the seizure activity. An accurate and detailed description of the seizure pattern (or patterns) is of paramount importance in determining localization. The most helpful component of the seizure pattern in localizing the site of origin of the seizure discharge is the initial seizure phenomena (aura), whether it be motor, sensory, vegetative, or psychical. Although descriptions by the patient and family are often helpful, the seizure pattern often can be determined with certainty only by direct observation and documentation of the patient's ictus by trained observers. Such observation is usually accomplished in the hospital as it is frequently necessary to reduce the anticonvulsant medication in order to observe ictal episodes and to obtain satisfactory electrical recordings. In this context, new systems permitting simultaneous electroencephalographic and videotape monitoring of such patients over substantial time periods are particularly helpful. Neuropsychological testing should also be an integral part of the patient's evaluation. It frequently yields valuable additional lateralizing and localizing data as well as evidence of specific cerebral dysfunction.

An intensive electroencephalographic study of the patient with epilepsy is essential. It should include recordings both on and off anticonvulsant medications and sleep recordings when necessary. Recordings during the initiation and course of clinical seizures are especially helpful. More specialized procedures such as hyperventilation, photic stimulation, and intravenous administration of pentylenetetrazol or methohexital may reveal epileptic foci in some patients. Pharyngeal and sphenoidal electrodes are particularly helpful in evaluating temporal lobe epileptics and may clarify problems encountered with bitemporal epileptic disturbances. The intracarotid brevital test is useful for determining the lateralization of cerebral speech dominance and for testing memory function in patients with temporal lobe epilepsy. In special circumstances, depth electrode recordings may be necessary to localize accurately the area of onset of the patient's seizures.

Plain roentgenograms of the skull should be reviewed for evidence of growth asymmetries, often a clue to a cerebral atrophic process dating from birth or early childhood. These films may demonstrate other evidence of a focal cerebral lesion or lesions such as localized thinning or erosion of bone, old fractures, abnormal intracranial calcifications, or signs of chronically increased intracranial pressure. Radioisotopic brain scanning is also useful in detecting some vascular malformations and certain cerebral neoplasms. Computerized axial tomography, cerebral angiography, and pneumoencephalography should be essential components of the clinical evaluation. Although cerebral angiography usually gives little or no valuable information in most patients with epilepsy due to a static

or atrophic lesion, it is principally of value in excluding cerebral vascular malformations and neoplasms. Computerized axial tomography and pneumoencephalography are often especially helpful in demonstrating localized areas of cerebral atrophy at the site of the epileptogenic focus, and, in addition, in excluding intracranial mass lesions (Fig. 1). An atrophic process is often demonstrated by some enlargement of that portion of the ventricular system nearest the lesion, with a tendency for that portion of the ventricle to migrate or protrude toward the lesion.

Once the diagnosis of epilepsy has been established and it is clear that the etiologic lesion does not itself need treatment, then the treatment of the symptoms, epilepsy, is in order. The goal of therapy is to prevent all seizures, with freedom from side effects, and therefore to allow the patient to live a normal life. If it is possible to achieve this goal with anticonvulsant drugs, there is obviously no indication for considering surgical therapy.

Although there is no perfect anticonvulsant medication, the current armamentarium of anticonvulsant drugs is large and growing.[3] The skillful use of these agents alone or in combination requires a systematic approach with patience and persistence on the part of both the physician and the patient. Of course, the criteria of failure of medical management are not fulfilled until every rational combination of agents has been utilized in the maximal dose that can be tolerated. The goal of therapy is often not accomplished rapidly, and tolerant tenacity is required, particularly when the seizures are relatively infrequent. Certainly medical therapy cannot be judged a failure because a patient continues to have seizures after receiving diphenylhydantoin or phenobarbital, alone or in combination, for a few months. The decision that medical management has failed and that the patient is a candidate for surgical intervention should be made only after careful consultation with the patient, his family, and personal physician. Due consideration must be given to the patient's intellectual, emotional, and social status and to his vocation. The repercussions from one or two seizures per month in an intelligent, socially responsible patient may be grave, while several

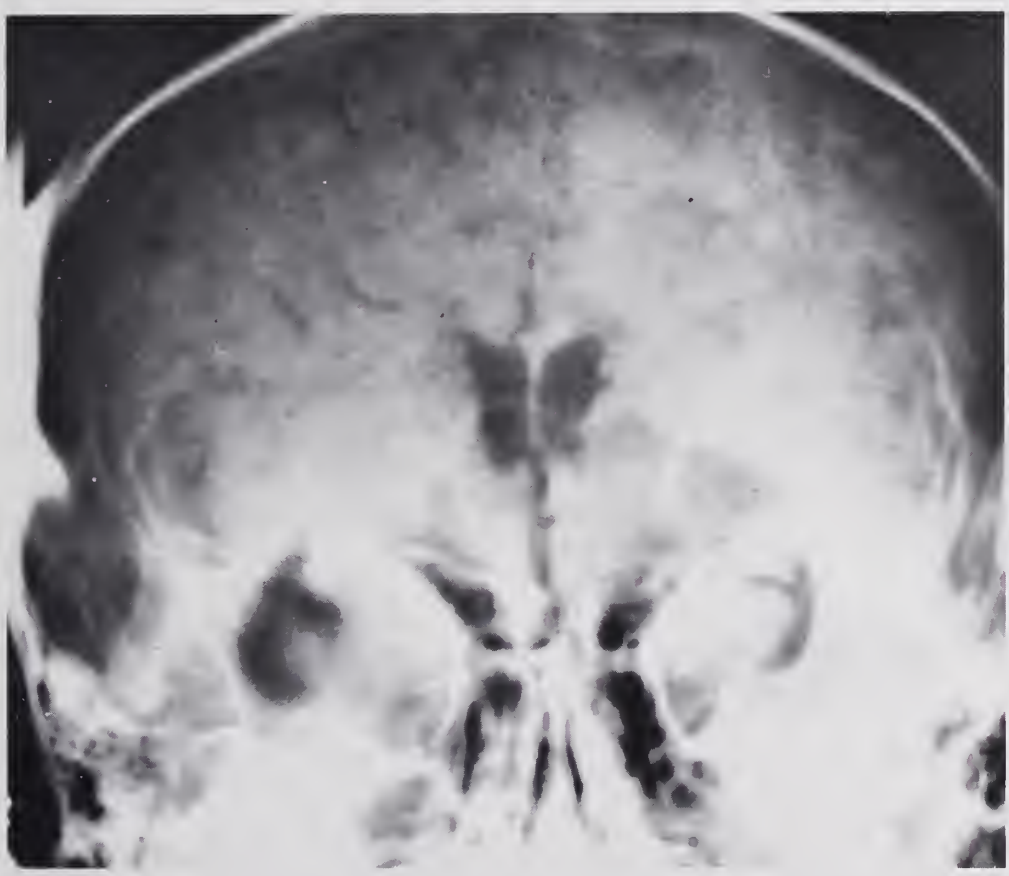


Fig. 1.—Anteroposterior pneumoencephalographic view of a 15-year-old patient with severely disabling intractable seizures. Repeated electroencephalographic examinations consistently revealed paroxysmal discharges arising in the anterior right temporal lobe. Note the localized enlargement of the anterior portion of the right temporal horn, consistent with a focal atrophic process (arrows).

seizures a day in a retarded, institutionalized patient may not constitute a serious problem. Furthermore, additional consideration must be given to the type and severity of attacks. When seizures are severe and frequent, particularly if associated with overt behavior disturbances or generalized motor involvement with loss of consciousness, they indicate a more pressing reason for considering neurosurgical management.

Since the frequency of seizures often changes during the first year or so after onset of attacks, no decision regarding neurosurgical management can be reliably made during this initial interval. In some patients, the seizure tendency may undergo a spontaneous remission. Hence, a stable baseline experience of seizure frequency and severity under controlled conditions of optimal anticonvulsant drug therapy is necessary to make an intelligent decision regarding surgical therapy. Generally, it is desirable to postpone neurosurgical therapy until the late teens or early adult life. This allows for a prolonged trial of medicinal therapy, a maximal opportunity for evaluation, and adequate motivation, understanding, and cooperation on the part of the patient. However, the more severe and disabling the seizure disorder regarding a child's intellectual and social development, the earlier it is advisable to consider neurosurgical therapy. Mild to moderate degrees of mental retardation are not contra-indications to surgery if the patient's family fully understands that the operation will not restore normal intelligence. In addition, episodic abnormal behavior, often harmful or aggressive in nature, may be (if closely associated with the patient's actual epileptic attacks) an important consideration favoring neurosurgical therapy. The duration of the seizures and the age of the patient do not appear to be factors which reduce the probability of an excellent neurosurgical result.

Surgery of Focal Epilepsy

It is not appropriate in this article to discuss the details of the neurosurgical techniques. The surgical procedure is long — often six to ten hours. Except in children, it is usually carried out under local anesthesia. The operation requires specialized electronic equipment, including stimulators and equipment for recording the electrical activity from the surface and depth of the brain (Fig. 2). To this may be added intricate amplifiers, recording equipment, and cathode-ray oscilloscopes. In addition to the surgical team, specialized personnel are also needed, including an experienced electroencephalographer and electroencephalograph technician, a trained observer for the patient, and an experienced anesthesiologist. The entire team must function in an efficient, coordinated fashion under the stressful conditions of the operating room and in the presence of a patient under local anesthesia. For these reasons, the neurosurgical management of each epileptic patient requires detailed, advanced planning even at institutions where such facilities and personnel

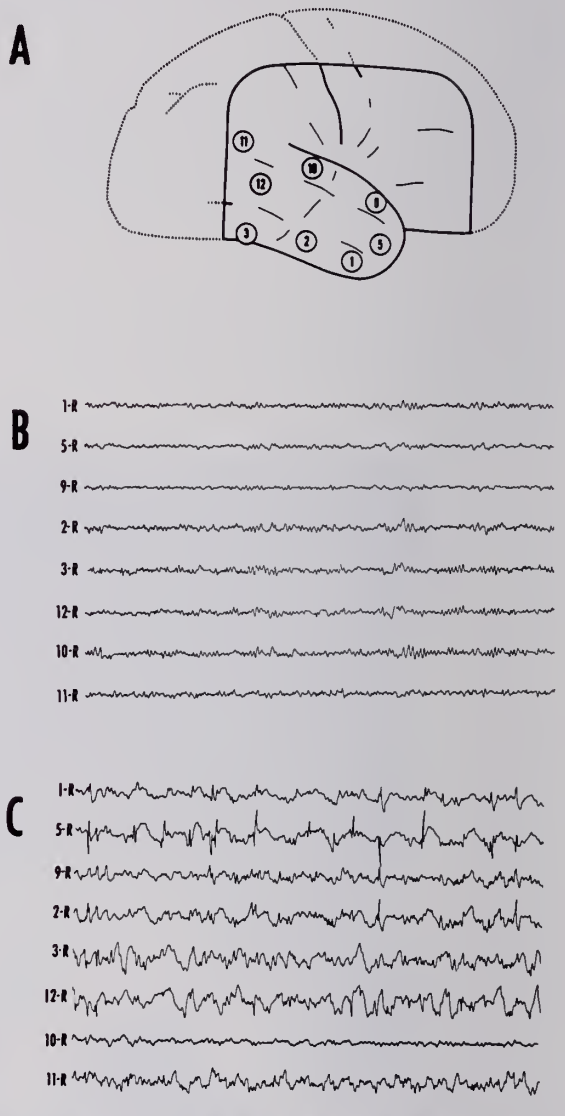


Fig. 2.—Electrocorticographic recordings at surgery from the same patient described in Figure 1. The craniotomy was performed under local anesthesia. (A) Schematic representation of the electrode montage corresponding to the recordings in (B) and (C). (B) Control record prior to the intravenous administration of methohexital. (C) Immediately after methohexital, spike discharges appeared in the record which were localized to the anterior right temporal lobe. Since subpial resection of the epileptogenic focus, this patient has had no seizures. Furthermore, he has demonstrated a well-documented increase of ten points in both verbal and performance I.Q. as well as a dramatic improvement in personality and educational performance.

exist. The motivation behind such massive efforts is the potential recovery of this group of patients who are severely disabled by their seizure disorder.

The evaluation of the results of a complex therapeutic procedure is difficult; this is particularly true of a process such as epilepsy where each patient represents a different problem and in which no two neurosurgical procedures can be identical. In addition, group statistics do not give a satisfactory depiction of the impact of success or failure in an individual patient, and this is the crucial information that is desired. In spite of these limitations, excellent data are available with long-term follow-up. In properly selected patients, approximately one-third will have a marked (worthwhile) reduction of seizure tendency. In the remaining one third (the less successful cases), a slight-to-moderate reduction in seizure tendency occurs. Furthermore, cortical resections for nontumorous epileptic lesions, controlled by electrical stimulation and recording techniques, carry a very low morbidity and mortality rate. The incidence of persistent hemiparesis and/or dysphasia should be less than 0.5% with an operative mortality rate less than 0.2%.

It is sometimes necessary to risk producing some deficits or, more frequently, increasing previous neurological deficits in patients with particularly severe seizures. An example is hemispherectomy as a treatment for infantile hemiplegia with intractable convulsions. The hemiplegia which is present at birth or develops in the early years of life has various etiologies such as cerebral hypoplasia, cerebrovascular disease, trauma, or encephalitis. The extremities contralateral to the damaged cerebral hemisphere are often small and atrophic with varying degrees of paresis and spasticity. In addition to intractable seizures, mental deficiency or personality disturbances manifested by aggressive, impulsive behavior and violent outbursts may be features of this disease. Together with a high degree of success in reducing the seizure tendency in these patients, hemispherectomy was observed to improve behavior in 31% and mental ability in 70% of the 150 cases reviewed by White.[4] Surprisingly, motor function was improved on the hemiplegic side in 33% and hemispherectomy aggravated the hemiparesis in only 6%.

Additional neurosurgical approaches to management of the intractable epilepsies include stereotaxic surgery and the implantation of brain (i.e., cerebellar) stimulating devices. These methods have been used to eradicate deep primary epileptogenic lesions, to interrupt well-defined pathways of seizure discharge, and to prevent the initiation and spread of seizure discharges. However, stereotaxic and brain stimulation techniques remain largely experimental efforts for the treatment of patients who are refractory to medical management and who do not meet the criteria for the usual neurosurgical resection.

Comment

Neurosurgical treatment of the epilepsies should be considered if the patient is disabled from seizures of focal onset that cannot be controlled by maximal, nondisabling medicinal therapy and if the epileptogenic lesion is localized within an area of dispensable cortex. The surgical therapy of epilepsy requires specialized facilities and skills and a team effort beginning with the initial evaluation and continuing through the patient's recovery and rehabilitation.

The main purpose of neurosurgical management is to reduce the seizure tendency. With some limitations, approximately one third of all patients will be totally free of seizures after operation, and an additional one-third will have a marked (worthwhile) reduction of seizure tendency. In the remaining one-third, or less successful cases, a slight or moderate reduction in seizure tendency occurs. With continuing improvements in our diagnostic techniques and surgical procedures, we can expect the neurosurgical therapy of the epilepsies to bring increasing benefit and hope to the epileptic patient who is disabled by intractable seizures.

References

1. Robb, P.: Focal epilepsy: The Problem, Prevalence, and Contributory Factors, in Purpura, D. P.; Penry, J. K., and Walter, R. D. (eds): Advances in Neurology, Vol. 8: Neurosurgical Management of the Epilepsies, New York, Raven Press, 1975, pp. 11-22.
2. Penfield, W. and Jasper, H. H.: Epilepsy and Functional Anatomy of the Human Brain, Boston, Little, Brown, and Company, 1954.
3. Sypert, G. W.: Neurosurgical Management of the Epileptic Patient, in Wilder, B. J.; Schmidt, R. P., and Sypert, G. W.: Contemporary Neurology Series, Vol. 11, Ed. 2: Epilepsy. F. A. Davis, 1976 (in press).
4. White, H. H.: Cerebral Hemispherectomy In the Treatment of Infantile Hemiplegia: Review of the Literature and Report of Two Cases, Confin. Neurol. 21:1-50, 1961.

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Ideas are funny little things, They won't work unless you do.

Anonymous

Head Injuries in a Community Hospital
Day-to-Day Management

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Abstract: The diagnosis and management of cranial trauma still remains a significant portion of the practice of neurological surgery. For this reason we have reviewed a consecutive series of 2,005 head injuries in our 600-bed hospital over a 20-year period. Emphasis has been placed on diagnostic techniques of reliability, value of specific surgical procedures, adequate supportive therapy in Intensive Care Units and, finally, results. The total mortality rate is 9% and has remained relatively stable. This apparent stability is due largely to the 23% increase in the total number of seriously brain-injured individuals.

It would appear that there is a small number of patients for whom no treatment is of any value but an intensive effort should be made in all cases until such instances become established.

Cranial trauma continues to play a major role in the daily practice of neurological surgeons. It might be of interest to our entire profession to note volume, rate of flow, type of cases and evolution of diagnostic aids, with a look at factors surrounding mortalities. Our experience comprises a 20-year period (1956 through 1975) and during this time 2,005 patients have been admitted to neurosurgical service at Halifax Hospital Medical Center. Hence, there has been a steady flow of approximately 100 cases per year. Ages ranged from 2 months to 87 years.

All patients with a history of unconsciousness as a minimum requirement were admitted regardless of physical signs. Skull films and echograms are obtained on all patients and cervical spine films on those who cannot communicate or have suspicious neurological signs and symptoms.

Types of Cases

1. Concussion: This sub-group comprised 1,215 patients or 60.5% of the total series. These patients had only a history of loss of consciousness with minor symptoms and no neurological deficit, but occasionally had a simple linear skull fracture.

2. Cerebral Contusion: This group of 391 patients or 19.5% includes those exhibiting minimal neurological dysfunction, lethargy, disorientation and amnesia beyond the time surrounding the accident itself. The extreme of this brainstem-injured group includes those with flexion of the upper limbs and extension of the lower ones (decorticate) and extension of all limbs (decerebrate tonus). Response to pain is absent and oculovestibulocephalic reflexes are impaired or absent. These have made up 221 cases or 11% of the series.

3. Intracerebral Hematoma: A localized collection of blood of any size within the brain, based solely on trauma, is extremely uncommon as evidenced by only 11 cases. Such cases have almost invariably been part of a severe generalized brain contusion with stem involvement as evidenced by a mortality rate of 54.5%.

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4. Epidural Hematoma: If early onset is recognized, this lesion is one of the most favorable for treatment. The so-called "lucid interval" is best demonstrated in this disorder. A linear skull fracture involving a vascular channel, generally the middle meningeal arterial groove, is present. Many of these patients have no damage to the brain itself. Hence the problem is simply one of rapidly increasing intracranial pressure to the point of fatality. The instance has been 0.74%, having experienced only 14 cases. On occasion decompensation of the brainstem occurs rapidly and may terminate fatally. This occurred on three occasions and one individual with multiple injuries was found to have an epidural hematoma in the posterior fossa due to a fracture crossing the lateral sinus, at postmortem examination.

5. Subdural Hematoma: Sixty-nine cases or 3.4% have shown these surface lesions. (We have included only those in which a diagnosis and treatment occurred during the first week following trauma).

A 40.5% mortality rate emphasizes the underlying brain contusion associated, including damage to the brainstem. Such damage is usually not seen in those appearing after the first week. Still, operative therapy seems justified as evidenced by the 41 patients who survived, or 59.5%.

6. Skull Fractures: The presence or absence of skull fractures is of prominent concern to everyone. In this series 359 or 17.9% had some variety of fracture, often occurring in association with other types of head injuries. These fractures fall into two major groups:

a. Simple Fractures: (1) Of the first group 177 linear fractures occurred. Important are those in which the presence of fracture line crossing a major vascular groove in the bone alerts one to early evidence of an epidural hematoma. (2) A simple depressed fracture occurred on only two occasions. If the depression is over 5 mm or the width of the entire skull, elevation can be justified especially if it overlies an important cortical area such as the motor cortex.

b. Compound Fractures: (1) Of the compound group the most common ones were the comminuted and depressed fractures of which we had 84 or 4.1%. All had surgical debridement except three terminal transcranial gunshot wounds. Debridement should be done as soon as practical unless there are overriding other serious injuries.[1] (2) Compound linear fractures need thorough debridement of the scalp with variable use of antibiotics. This occurred in 28 patients or 1.44%. (3) Patients with bleeding from an orifice of the head, with or without a demonstrable basilar fracture, are observed for any CSF fistula. If such occurs, the sitting position in bed, dehydrating agents, and repeated lumbar punctures aid in control of the leak. Antibiotics are advised by some[2] with or without leakage. We have used Ampicillin routinely. Only one patient with this type fracture and persistent CSF required surgery (at another hospital).

7. Other Major Injuries: (Usually extremity fractures) These have occurred in 110 cases or 37.3%. Those with major head trauma died of brainstem decompensation, not other injuries, with the exception of one case of severe pulmonary damage. We have had no proven instance of fat embolism.

8. Diagnostic Appraisal:

a. Patients are observed for 18 to 24 hours in a Care Unit[3] and assessed according to the plan described by Talalla[4] (1) Alert; (2) Arousable verbally with effort, with equal movement; (3) Arousable only by pain, with or without hemiparesis, pupillary alterations or decortication, and (4) In coma, with decerebration and absence of oculovestibulocephalic reflexes.

b. Echography, used to determine the intracranial midline, is a valuable and impressive aid. During the past eight years accuracy, based on 166 surgical cases, was found to be 98.2%, with two false negatives and one false positive tracing. The latter was due to the wrong laterality in a case of subdural hematoma. Pineal gland position should be sought for on plain films.

c. Due to scalp injuries, technetium scans are of little value in acute cases.

d. The "Twist Drill Procedure" as described by Rand et al[5] is another valuable diagnostic aid. This is done by a neurological surgeon or a surgically-oriented Emergency Department physician. Its two important functions are in diagnosis and occasionally "buying time" by partial hematoma aspiration while the operating room is being prepared. Openings are made over the convexity in the frontal, parietal and temporal regions. Firm resistance to the #16 canula at 2 to 3 cm suggests dura (probable epidural hematoma). Less resistance suggests brain surface or subdural hematoma. Sometimes softened brain tissue is recovered from the needle, thus differentiating from a collection of

blood. This procedure has been done 12 times in extreme cases. On six occasions a hematoma was found, with two excellent recoveries following definitive surgery.

e. Carotid angiography is pathognomonic of surface hematomata and has a high accuracy in locating subcortical lesions. However it is not a screening procedure, carries some risk, and requires time. If time permits, burr openings should be made after carotid arteriography has located a mass. With increasing apnea and deepening coma, twist drill openings can be employed.

9. Summary of Types and Results of Therapy:

a. General Care: Monitoring of consciousness, pulse, blood pressure, temperature and occasionally intracranial pressure using a closed catheter connected to a venous manometer, is carried out. Selected cases of a semicomatose nature should be monitored routinely.

Alcohol, barbiturate and blood sugar levels are determined. Fluids are limited to 1500 cc for 48 to 72 hours, with gradual resumption of oral fluid and if necessary nasogastric tube infusions. Steroid therapy has been used in comatose patients. If mass lesions have been ruled out, control of intracranial pressure can be a problem. With measurable elevation we have used Mannitol 20%, 1 to 2 gm/kg daily for 2 to 3 days. Respiratory support is necessary in the more seriously injured. Comatose patients are almost invariably intubated on admission, enabling the use of hyperventilation to reduce intracranial pressure. Blood gases are determined as desired. A tracheostomy is carried out if long-term management seems needed. Metabolic functions are followed as described by McLaurin and King[6] noting electrolytes, tonicity of serum and urine, keeping the tonicity below 310 mOsm. Antibiotics are sometimes used and sedatives are used sparingly. Chlorpromazine has been successfully used for decerebrate tonus and sodium luminal for general restlessness.

b. Summary of Surgical Results: Our surgical efforts centered around 166 cases or 8.2% of the series. During the years 1956 to 1973, 11.8% of 1,736 patients had surgery. During the past three years, based on 294 patients, the rate was 8.2%. This lower percentage is probably due to more effective diagnostic aids.

Type of Case	Number Cases	Percent Series	Deaths	Mortality Rate
Subdural Hematoma	69	41.5	28	40.5%
Epidural Hematoma	14	8.4	4	28.5%
Intracerebral Hematoma	11	6.6	6	54%
FCC and F.Simp. Comm.	84	50.	12	9%
Carotid Cavernous Fistula	1	.06	0	0%

10. Overall Results of Series:

a. The total surgical mortality is 22.8%.

b. Overall mortality of total series is 9%, representing 181 deaths. One hundred thirty-six deaths or 75% occurred within 96 hours of admission. Twenty-three brain-damaged patients per year were seen from 1956 to 1973 and 30 from 1973 through 1975, or 23% increase.

11. Late Sequellae: Significant neurological deficit was sustained in 44 cases. Included in this group were those with dementia, hemiparesis, seizures, cranial neuropathies and aphasic disorders in various combinations. These deficits persisted for six months or longer and the individuals are not gainfully employed. Only one patient is incapable of self care.

Summary

In the past 20 years 2,005 consecutive head injuries have been evaluated in our 600-bed community hospital. The mortality rate has changed little. The rate of serious injury has increased, probably due to trauma to the brainstem at the time of injury. Centralization of care should be encouraged in that sophisticated care may be available to the injured patient.

References

1. Jamieson, K. G. and Yelland, J. O. V.: Depressed Skull Fractures in Australia, J. Neurosurg. 37:150-155, 1972.
2. Lewin, W.: Management of Head Injuries, 85-87, 1966.
3. Brackett, C. E. Jr.: Administration, Staffing, and Design of Intensive Care Unit, Clin. Neurosurg. 22:389-410, 1975.
4. Talalla, A. and Morin, M. A.: Acute Traumatic Subdural Hematoma, Review of One Hundred Consecutive Cases, J. Trauma 11:771-777, 1971.
5. Rand, B. O.; Ward, A. A. Jr., and White, L E. Jr.: Use of Twist Drill to Evaluate Head Trauma, J. Neurosurg. 3:410-415, 1966.
6. McLaurin, R. L. and King, L. R.: Metabolic Monitoring of Neurosurgical Patients, Clin. Neurosurg. 22:476-486, 1975.

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Prudence is the footprint of wisdom.

A. Bronson Alcott

Normal Pressure Hydrocephalus
A Treatable Cause of Dementia

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Abstract: This article reviews normal pressure hydrocephalus, a treatable cause of dementia. Dementia, or mental deterioration, is commonly encountered in dealing with the elderly. If severe and no treatable cause is found, confinement to a nursing home may be required. Normal pressure hydrocephalus usually presents with dementia, gait disturbances and urinary incontinence. Laboratory criteria based on computerized axial tomographic scanning, pneumoencephalograph and intrathecal radioisotope studies are reviewed. Dementia is frequently reversible with cerbrospinal fluid shunting.

Progressive mental deterioration or dementia is one of the more frequent neurological disorders encountered by the physician caring for the elderly patient. The prognosis is frequently poor unless a treatable infection or tumor can be found, and too often the patient requires placement in a long-term care facility. The investigation then ceases with a final diagnosis of cerebral arteriosclerosis or senile dementia.

However, in the past several years it has become possible to isolate a small group of patients with dementia who can be treated by cerebrospinal fluid shunting, a relatively low risk surgical procedure. Since the initial report by Harkim and Adams,[1] many studies have followed advocating shunting the ventricular fluid in certain patients who have a peculiar symptom complex, thus providing a new hope for some patients with this severely incapacitating disease.

It is the purpose of this article to present some of the signs and symptoms, so as to remind all of us of the importance in recognizing this syndrome, which too often appears subtle in its onset and progression.

Clinical Findings

Normal pressure hydrocephalus (NPH) reveals itself as a significant impairment in memory and mental slowing, progressing over weeks or months to a disabling dementia. The usual onset occurs in the 50-70 year age group without a predilection for either sex.

The mental changes can be described as an inability to concentrate, paucity of thought, lack of interest or apathy. An unusual symptom in this illness is an emotional lability from a feeling of well-being to sudden, unprovoked depression and crying.

Gait disturbance without a specific lower extremity weakness is a characteristic finding. The problem seems not to be purely a motor deficit, but rather an inability or lack of comprehension of gait. Patients with NPH seem to have lost the integration of the cerebral with the motor part of the gait process.

Urinary incontinence is a third significant symptom in normal pressure hydrocephalus.

These three cardinal findings, progressive dementia, gait disturbance and urinary incontinence, have become known as the triad of normal pressure hydrocephalus and may be the only clues in the history or physical examination.

Confirmatory Laboratory Findings

As the name indicates the cerebral spinal fluid pressure is normal. The monometric fluid pressure when measured in the supine patient is not significantly elevated above the normal 180 mm H_2O.

The pneumoencephalogram reveals a nonobstructive symmetrical ventricular enlargement in

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spite of the normal spinal pressure. Air does not reach the cortical surfaces as frequently seen in generalized cerebral atrophy. This finding helps in distinguishing NPH from Alzheimer's disease, a more frequent cause of dementia.

Recently, computerized axial tomography or the EMI scan has become available which has eliminated the need for pneumoencephalography. Symmetrical ventricular enlargement and a lack of prominent cerebral sulci can be recognized on the scan suggesting the diagnosis.

The widely available RISA scan, performed by the injection of a radioactive iodinated serum albumin into the lumbar subarachnoid space, shows a pattern of abnormal cerebral fluid flow. The radioactively traced CSF can be followed by repeated scan, and can be demonstrated to rise from the lumbar subarachnoid space into the ventricles. Absent or slowed transfer from the ventricles over the cortical surfaces is a confirmatory finding of NPH.

A Possible Mechanism

In the normal state a delicate balance exists between spinal fluid production and absorption. Any pathological process that interferes with the cerebral fluid circulation leads to development of hydrocephalus. The ventricles enlarge and brain tissue is compressed. If the block is complete the pressure can rise to a point where cerebral function ceases resulting in death. However, usually a state of equilibrium between absorption and production is reached whereby the ventricles remain enlarged, but neurological symptoms persist. The new relationship of volume and pressure now follows the law of fluid dynamics enunciated by Pascal several centuries ago. He described that a given pressure of enclosed fluid has a greater force when applied to the walls of a large vessel than a small one. Therefore, ventricles of two different sizes may be under the same pressure, but the force exerted on the walls of the larger one will be greater.

A partial anatomical explanation of the symptom triad can be found on the basis of this ventricular enlargement. The gait disturbance and bladder incontinence could be attributed to compression of cortical fibers descending along the medial ventricular wall. The mental and intellectual impairment observed has to be the result of frontal lobe and perhaps temporal lobe dysfunction by the relative increased ventricular pressure in an enlarged ventricular space, since a rapid improvement in mental function is frequently observed when the pressure is lowered.

Most often a specific antecedent cause cannot be found to explain the onset of this syndrome. However, in some individuals a recent subarachnoic hemorrhage or meningitis can be implicated in which case obstruction of absorptive pathways of cerebral spinal fluid led to the hydrocephalus.

Treatment

An effective change in force exerted on the enlarged ventricles can be accomplished by permanently lowering the ventricular pressure. This can be accomplished by shunting the ventricular fluid into the vascular or peritoneal cavity, an operative procedure performed for over 20 years for hydrocephalus. This relatively low risk procedure is performed by placing a catheter into the ventricles and shunting the fluid through a subcutaneous catheter and valve into the right atrium of the heart or the peritoneal cavity. The cerebrospinal fluid pressure is then considerably below the 180 mm H_2O.

Conclusion

In our own experience we have found frequent dramatic changes in the mental, gait and urinary problems in patients with NPH after placement of a Holter shunt. A specific etiological factor could usually not be demonstrated except in a few cases where a subarachnoid hemorrhage from an aneurysm had occurred at a variable time before the onset of symptoms. Unfortunately, among the many patients seen in a neurological practice with complaints of dementia, only a relatively small number conform to the expected laboratory findings of NPH. An initial earlier enthusiasm by many neurosurgeons to suggest operation when dementia and ventricular enlargement was found has in general met with failure, for too often Alzheimer's disease is mistaken as NPH. But even if only a few patients can be returned to once again function in society and not be abandoned in a nursing home a significant contribution has been made and, therefore, we have to remain cognizant of this syndrome.

Reference

1. Harkim, S. and Adams, R. O.: Special Clinical Problem of Symptomatic Hydrocephalus with Normal Cerebral Spinal Fluid Pressure, J. Neurol. Sci. 2:307-327, 1965.

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Intracranial Pressure Monitoring in Clinical Practice

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Abstract: Intracranial pressure monitoring is an important new clinical tool. Over the past five years the author has monitored intracranial pressure (ICP) in a large number of patients with head injury, brain tumor, and aneurysm. It has proven to be simple and safe to perform. Information from ICP monitoring has played a critical role in the management of a large percentage of these patients.

The first major work on intracranial pressure (ICP) monitoring was published by Lundberg in 1960.[1] He systematically studied the relationship between the clinical state of neurosurgical patients and the level of the ICP. Since that time there has been increasing recognition of the usefulness of ICP monitoring in patients with intracranial disease. The following paper outlines our experience in this area over the last five years.[2-8] It confirms the value of ICP monitoring in patients with head injury, brain tumor and aneurysm.

Methods and Materials

1. Early ICP Determination in Head Injury Patients

The ICP is determined in all patients with signs of severe head injury upon arrival at the emergency room.[8] This is accomplished by tapping the lateral ventricle through a coronal twist drill hole. The actual measurement is made with a water manometer. Five cc of air is then exchanged into the ventricle for a brow up ventriculogram. The results of this procedure are used to make a management decision according to the following guidelines: (1) patients with an elevated ICP (greater than 11 mm Hg) and a midline shift have an immediate exploratory craniotomy; (2) patients with elevated ICP without a midline shift have an immediate angiogram or EMI scan; (3) patients without a midline shift and normal ICP are admitted to the intensive care unit for continuous ICP monitoring and elective neuroradiologic studies.

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2. Continuous ICP Monitoring

ICP is monitored on a continuous basis by one of the following two methods: (1) the ventricular catheter technique; or (2) the hollow screw technique.[1,6] In the ventricular catheter technique a #5 Argyle infant feeding tube is inserted into the lateral ventricle through a coronal twist drill hole using a stylet. To lessen the chance of infection the feeding tube is tunneled through the scalp so that the point of emergence is remote from the twist drill hole. In the hollow screw technique a connection is established with the subarachnoid space over the cerebral convexity. This is accomplished by screwing a special hollow screw into a ¼ inch twist drill hole after the dura and arachnoid have been opened. This latter maneuver is done under direct vision with the aid of a #11 scalpel blade and an angled currette.

The choice of monitoring methods is dependent upon the individual situation. The ventricular catheter technique has the advantage of allowing CSF drainage for therapeutic purposes. The hollow screw technique has the advantage of not requiring a ventricular puncture. In most cases patients with head trauma are monitored with the hollow screw technique. This is also true of patients with supratentorial brain tumors. Most patients with infratentorial brain tumors and aneuryms are monitored with the ventricular catheter technique.

3. Monitor Connections

A disposable stopcock network is used to connect patients to the recording and display system.[5] The same network is used for both the ventricular catheter and hollow screw monitors. The network contains a strain gauge transducer and a closed water manometer system for calibration. The entire network moves up and down on an IV pole as a unit. This allows corrections for the height of the patient without the necessity of recalibrating the transducer. The ICP is displayed on a bedside oscilloscope so that the wave form can be observed. A permanent record of the ICP is made on a centrally located strip chart.

Results and Discussion

Early ICP measurement has been performed in over 300 patients with severe head injury since 1971. A satisfactory measurement has been obtained in 95% of cases.[4,8] The entire procedure has generally required 10-15 minutes to complete including the taking of x-rays. The results of this procedure in 100 consecutive patients are shown in Table 1. It is noteworthy that all patients with surgically significant mass lesions had elevated ICP. In more than half the cases the elevation was sufficient to compromise cerebral perfusion. Every patient who was taken to the operating room on the basis of elevated ICP and midline shift was found to have a significant mass lesion. None of the patients with normal ICP and midline ventricles had mass lesion. Approximately 90% of patients with elevated ICP without a shift had bilateral cerebral contusions with edema. The remainder of these patients had bilateral mass lesions, or a unilateral mass lesion balanced by a cerebral contusion. The use of early ICP measurement in these head injury patients greatly speeded definitive diagnosis and treatment.

Continuous ICP monitoring provided an early warning of mass lesion in this group of patients. In these situations the ICP became elevated 1-8 hours before clinical signs appeared. This confirmed that ICP monitoring was superior to clinical monitoring for this purpose.[9] ICP monitoring also allowed the safe use of central nervous system depressants to control ventilation, blood pressure, and temperature. There is strong evidence that control of these systemic physiologic parameters within defined limits can improve the outlook for these patients.[4,10]

The results of preoperative ICP monitoring in 50 patients with brain tumor are shown in Table 2. Examination of the data reveals that patients with gliomas, metastatic lesions, and posterior fossa tumors tended to have high levels of ICP in contrast to patients with meningiomas. The degree of intracranial compensation in each case could be judged by the level of the ICP and the presence of plateau waves. The effect of treatment with steroids was interesting to note. In some patients there was no effect, while in other patients there was a decrease in the mean ICP or the frequency of plateau waves. This confirms the observations of Kullberg.[11] In preoperative patients who showed marginal degrees of compensation, ICP monitoring was continued during the induction of anesthesia as an additional safeguard.[7,12] Postoperatively knowledge of the ICP provided an early warning of mass lesions similar to the situation for head injury. This is illus-

SEVERE MECHANICAL BRAIN INJURY

ICP (mm Hg.) AT ADMISSION

	0-10	11-29	30-50	>50	Total
Acute Subdural Hematoma		2	6	9	17
Acute Epidural Hematoma			5	1	6
Acute Major Intracerebral Mass		10		3	13
Diffuse Cerebral Injury	18	35	9	2	64
Total					100

TABLE II

PRE-OPERATIVE BRAIN TUMOR MONITORING

	CPP mm Hg.		ICP mm Hg.			Plateau	Papille-	Hydro-	Reduction of Mean ICP
	<60	>60	<10	11-39	>40	Waves	dema	cephalus	by Steroids
Glioma	1	15	3	6	7	7	5	1	14
Metastasis	1	15	6	8	2	1	2	0	8
Meningioma	0	7	5	2	0	0	1	1	2
Post. Fossa Tumor	0	11	4	7	0	1	3	4	4
Total	2	48	18	23	9	9	11	6	28

trated in Figure 1 which shows the postoperative ICP record of a patient with a cerebellar hemangioblastoma. A steady rise in ICP produced by acute hydrocephalus was detectable long before the clinical signs appeared.

3. Aneurysms

ICP monitoring was performed both pre- and postoperatively in patients with ruptured intracranial aneurysm. The preoperative record from a patient with a right internal carotid artery aneurysm is shown in Figure 2. The sudden sharp rise in ICP was caused by an episode of rebleeding. The late rise in ICP represented the development of hydrocephalus and edema. The record of a patient who underwent clipping of a right middle cerebral artery aneurysm is shown in Figure 3. This patient deteriorated neurologically while the ICP remained low. This implied that the cause of the deterioration was

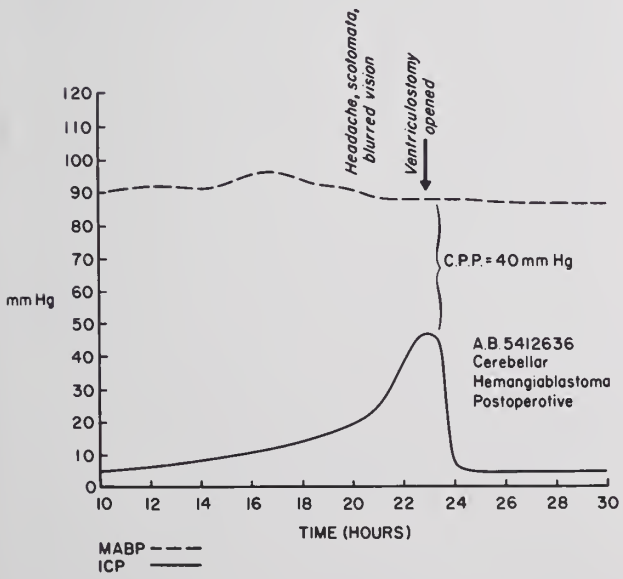


Fig. 1.—Postoperative ICP record of a patient who developed acute hydrocephalus. The slow gradual rise of ICP was apparent 6-8 hours before symptoms appeared.

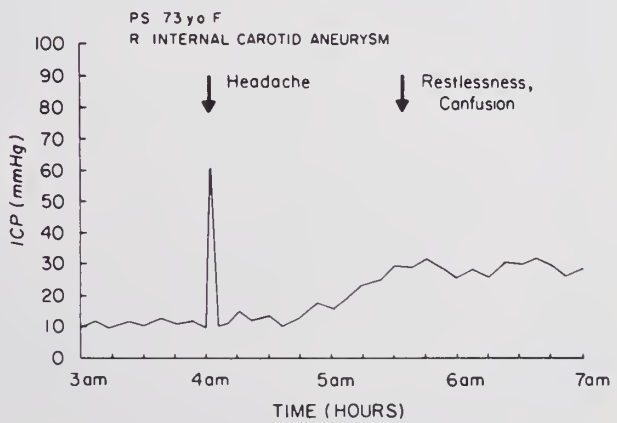


Fig. 2.—Preoperative ICP record of a patient who had bled from an aneurysm. The sudden sharp rise in ICP at 4 a.m. represented an episode of rebleeding.

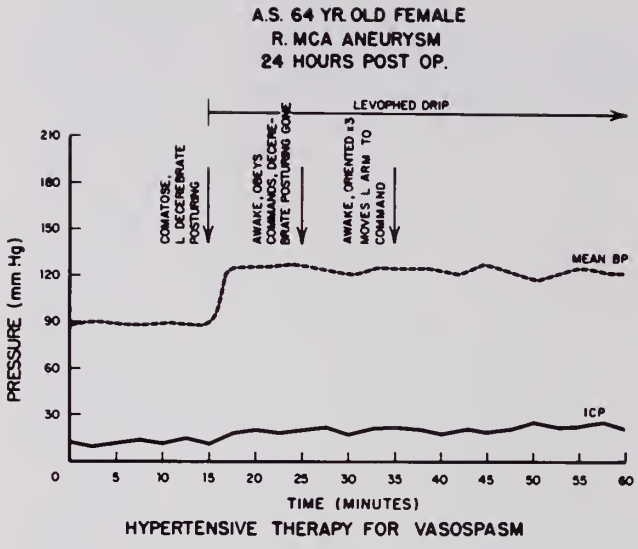


Fig. 3.—Postoperative ICP record from an aneurysm patient with vasospasm who was treated with hypertensive therapy. There was a mild rise in ICP after the institution of therapy which then stabilized.

spasm rather than hydrocephalus, edema or postoperative clot. The patient subsequently improved on hypertensive therapy. ICP monitoring proved useful for detecting small episodes of rebleeding, for differentiating spasm from mass lesion effect, and for detecting cerebral edema during the course of hypertensive therapy. In general our ICP recordings confirmed the observations of Nornes.[13]

Conclusion

ICP monitoring has proven extremely useful for the management of patients with head injury, brain tumor, and aneurysm. It has been simple and safe to perform. The information obtained from ICP monitoring has been critical to the outcome in a significant number of cases.

References

1. Lundberg, N.: Continuous Recording and Control of Ventricular Fluid Pressure in Neurosurgical Practice, Acta Psychiat. Neurol. Scand. 36: Suppl. 149, 1-193, 1960.
2. Becker, D. P. and Vries, J. K.: Alleviation of Increased Intracranial Pressure by Chronic Administration of Osmotic Agents, In Brock, M. and Dietz, H. (eds): Intracranial Pressure; Experimental and Clinical Aspects, Springer-Verlad, Berlin, pp. 309-315, 1972.
3. Becker, D. P.; Young, H. F.; Vries, J. K., and Sakalas, R.: Monitoring in Patients with Brain Tumors, Clinic. Neurosurg. 22:364-388, 1975.
4. Vries, J. K.: Continuous Intracranial Pressure Monitoring in Patients with Brain Injury; Technique and Application, MCV Quart. 10 (4):174-177, 1974.
5. Vries, J. K. and Becker, D. P.: Equipment of Intensive Care Unit, Clinc. Neurosurg. 22:411-421, 1975.
6. Vries, J. K.; Becker, D. P., and Young, H. F.: Subarachnoid Screw for Monitoring Intracranial Pressure. Technical Note, J. Neurosurg. 39:416-419, 1973.
7. Vries, J. K.; Young, H. F., and Becker, D. P.: Practical Means to Monitor Intracranial Pressure in Operating Room. Presented at American Association of Neurological Surgeons Meeting, St. Louis, Mo., April 1974.
8. Vries, J. K.; Young, H. F.; Sakalas, R., and Becker, D. P.: Recent Advances in Management of Head Injury Patients, Virginia Med. Month. 100:1117-1122, 1973.
9. Johnston, I. H.; Johnston, J. A., and Jennett, W. B.: Intracranial Pressure Changes Following Head Injury, Lancet 2:433-436, 1970.
10. Gordon, E.: Controlled Respiration in Management of Patients with Traumatic Brain Injuries, Acta Anaesth. Scand. 15:193-208, 1971.
11. Kullberg, G. and West, K. A.: Influence of Cortico Steroids on Ventricular Fluid Pressure, Acta Neurol. Scand., 41: Suppl. 13, Part 2, 445-452, 1965.
12. Jennett, W. B.; Barker, J.; Fitch, W., and McDowall, D. G.: Effect of Anesthesia on Intracranial Pressure in Patients with Space Occupying Lesions, Lancet 1:61-64, 1969.
13. Nornes, H. and Magnaes, B.: Intracranial Pressure in Patients with Ruptured Saccular Aneurysm, J. Neurosurg. 36:537-547, 1972.

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The cynic is one who never sees a good quality in a man, and never fails fails to see a bad one;

The cynic is one who knows the price of everything and the value of nothing.

Oscar Wilde

Cranioplasty
Use of a Combination Graft

Jack E. Maniscalco, M.D., Donald Leake, D.M.D., M.D., and Mutaz B. Habal, M.D.

Abstract: This paper describes a method which combines an alloplastic material with autogenous bone for repair of major cranio-orbital defects. This combination graft incorporates the advantages of both materials while attempting to minimize the disadvantages of each when used individually. The alloplastic portion of this combination graft is used to produce a smoothing effect over the area of reconstruction. Below the alloplast and into the area of the defect, autogenous bone is placed. Bone graft has the physiologic advantage of serving as a latticework for future bony ingrowth and osteoneogenesis. This new technique is effective in producing both strong protection for the brain and excellent esthetic results.

For years, cranial defects have been repaired using various materials and techniques.[1] The types of material used have been limited only by man's imagination. According to one early report, South Sea Island Indians used coconut shells to accomplish their corrective surgery.[1]

Newer methods have included the use of gold, silver, tantalum, silastic, and methylmethacrylate. Each one of these agents has its advantages along with its problems. Briefly, acrylate is simple to use and can be molded easily at the time of surgery. Its disadvantage lies in the fact that acrylate, because of its semiliquid form is difficult to contour and tends to flatten out if left unattended. Furthermore, a plate of uniform thickness is difficult to fashion at the time of surgery. When using acrylate some surgeons, including one of the authors, have advocated prefabrication of these plates utilizing dental impression techniques.[2] In spite of these difficulties, methylmethacrylate has been the agent most widely used by neurosurgeons.

The repair of a cranial defect must encompass several technical objectives. Protection of the underlying brain has high priority on the list of factors to be considered. Equally important, at least to the patient, is the esthetic outcome of the operation.

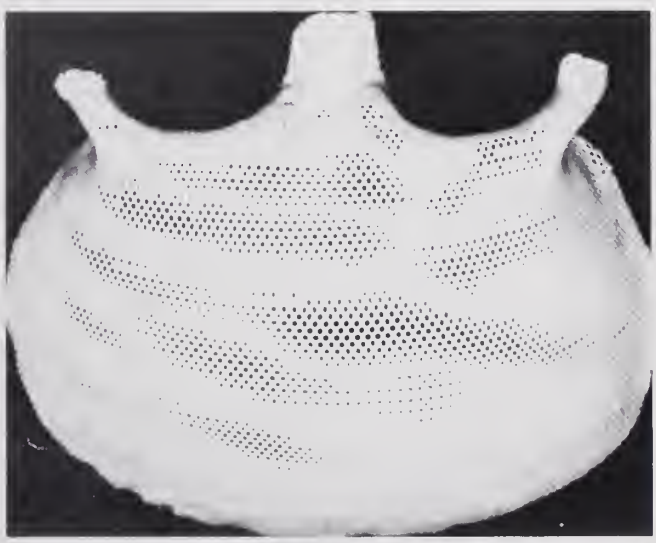


Fig. 1.—Polyurethane terephalate mesh used for reconstruction of forehead and orbital regions. The mesh is rigid and capable of providing contoured surfaces, yet, may be trimmed with scissors.

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It is not enough to have provided protection for the brain while leaving the psyche of the patient vulnerable to injury. Ideally, today's selection of a material for repair should consider the following criteria: the cranioplasty should be strong, conduct temperature poorly, be radiolucent and readily malleable or moldable.

This report describes a material that has been used in conjunction with patients' autogenous bone to repair cranial defects. The material, dacron mesh impregnated with polyurethane, is moldable and can be fashioned preoperatively to fit any area of the cranium. Success with this method in reconstruction of defects of the lower facial region, i.e., chin, alveolar ridge and mandible, prompted our adopting it for cranioplasties.[4]

Method

Figure 1 is a photograph of a polyurethane mesh model and illustrates the various forms used for reconstructions. The material is available in sheets of surgical dacron which is flimsy and must be impregnated with polyurethane to obtain rigidity and form. Preoperatively, the prosthesis is molded on either a cranial moulage of the patient or a cadaver's skull. Allowed to dry the polyurethane dacron mesh assumes a semirigid form which is then chemically cured in an air circulating oven for several hours. Prior to use, the mesh is autoclaved in a standard steam unit.

The term "combination graft" connotes the use of more than one agent. In conjunction with the above described prosthesis, autogenous bone taken from convenient donor sites such as the chest wall (rib) or iliac crest are used. The autogenous material is cut, split and bent as much as possible to provide some contour to the repair. Experience and studies have taught us that bone grafts should be split to expose as much cancellous bone as possible. By doing so, one enhances the revascularization of the bone graft and subsequent osteoneogenesis.[3] Bone dust and cancellous bone alone are sufficient to produce osteoneogenesis and were the only autogenous agents used in the repair of the case illustrated in this paper. No matter how artistic or how much effort is expended by the operating surgeon, bone grafts have the disadvantage that they frequently leave irregularities on the surface making the cosmetic results less than optimal. To overcome this problem, the prosthetic mesh is placed over the defect area and creates a smooth contour with the surrounding skull. The mesh may be secured in place with either sutures or tiny screws. We prefer the latter because of the rigid fixation that is obtained as well as the ease of use. Figure 2 is a preoperative photograph of a patient with a frontoorbital defect. Figure 3 demonstrates the defect at the time of surgery filled with ground up pieces of cancellous bone chips (taken from the iliac



Fig. 2.—Preoperative photograph of patient demonstrating cranial defect extending into rim and roof of left orbit.



Fig. 3.—Intraoperative view of exposed defect. The area of the defect has been filled with cancellous bone and bone dust taken from the right iliac crest.



Fig. 4.—Intraoperative appearance of polyurethane mesh secured into place over the defect.



Fig. 5.—Postoperative photograph of patient taken one month after surgery.

crest). The prosthesis is shown secured into place in Figure 4 and the postoperative result after one month is demonstrated in Figure 5.

Discussion

With all the methods and materials available for repairing cranial defects one may query the need for yet another technique to add to the extensive list. Nevertheless, because of the shortcomings of the present established methods of cranioplasty, the combination graft repair was developed. Autogenous bone has the inherent advantage of being accepted by the surrounding tissue and eventually incorporated and fused into the surrounding skull defect. This is in contradistinction to any prosthetic device or alloplastic graft known to date. The problem of bone graft reabsorption and the difficulty with obtaining good, immediate cosmetic results have discouraged wide acceptance of this physiologic material. The technique described in this paper has largely resolved these problems by combining the individual advantages of autogenous and alloplastic materials. Our experience with ten patients, all with large cranio-orbital defects, has demonstrated that grafts healed well and fused solidly after a postoperative period of 6-12 months. The incidence of infection or rejection is zero and the esthetic results quite acceptable.

Lastly, we believe if the removal of the polyurethane prosthesis becomes necessary several months after implantation, this could be done with little risk to the underlying bone graft. After this length of time, should the mesh become contaminated from a scalp laceration, for example, the material could be easily removed without necessarily sacrificing the entire reconstruction. The autogenous bone graft, once vascularized, will resist osteomyelitis and should obviate the need for extensive debridement.

In summary, a method has been described for performing cranial vault repairs using a combination of autogenous and alloplastic materials. The use of these two agents combines the advantages of both and attempts to overcome the individual disadvantages of each. Dacron mesh impregnated with polyurethane is as of yet unavailable commercially. A brief description of the material and its manufacture is provided. This form of cranial repair meets the following criteria: the repair is ultimately strong and provides good protection for the underlying brain. The combination graft is a poor conductor of temperature and is also radiolucent. Furthermore, the combination graft eventually fuses to the surrounding skull thus providing rigid fixation and ultimately good brain protection. Lastly, the operation provides excellent esthetic results.

References

1. Reeves, D. L.: Cranioplasty, Springfield, Illinois, Charles C. Thomas. 1950.
2. Maniscalco, J. E. and Garcia-Bengochea, F.: Cranioplasty: A Method of Prefabricating Alloplastic Plates, Surgical Neurol. 2:339-341, 1974.
3. Mowlem, R.: Cancellous Chip; Bone Graft on 75 Cases, Lancet 2:746-750, 1944.
4. Leake, D. L. and Habal, M. B.: Osteoneogenesis: A New Method For Facial Reconstruction, J. Surg. Research, 18:331-334, 1975.

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Cervical Disc Disease and Other Causes of Upper Extremity Pain

James D. Geissinger, M.D. and Frank M. Davis, M.D.

Abstract: The differential diagnosis of upper extremity pain not uncommonly confronts the primary care physician. Many of these patients because of associated chest discomfort are first seen by the cardiologist. More commonly they are thought to have "bursitis." Rupture of a cervical intervertebral disc or cervical spondylosis are common sources of such pain. Familiarity with the pathology, history of presentation, clinical and laboratory findings enables the family physician to recognize the agent responsible for the pain and to initiate early therapy or referral. Appropriate conservative or surgical therapy is usually quite effective and in most instances relieves the pain and reduces future disability. Another condition recognized in recent years as a very common cause of hand and arm pain is the carpal tunnel syndrome. Recognition and treatment of this condition is quite rewarding. Other diseases of neoplastic, neural and vascular origin are included in the differential diagnosis.

Because the primary physician is frequently confronted by a patient with complaints of pain, numbness, paresthesia or weakness in an upper extremity, it is important that he have a differential diagnostic framework in which he can readily work. A well directed concise history and reasonable neurological examination will in most instances inform him as to the problem and will aid in treatment or referral.

Acute Rupture of Cervical Disc

We are referring to rupture of the annulus fibrosis and compression of the nerve root by soft disc material.

Case 1 illustrates this problem.

This 50-year-old librarian had been treated for two weeks by her physician for severe neck and left arm pain thought due to "bursitis." Neurosurgical evaluation revealed a lady with incapacitating pain, absent left triceps reflex and left elbow strength sufficient only to overcome gravity.

From Tallahassee Neurological Clinic and the Tallahassee Memorial Hospital, Tallahassee.

After confirmation of an acute disc rupture by myelography (Fig. 1), an anterior discectomy and fusion were done. Later films showed excellent fusion (Fig. 2) in this patient who returned to work in four weeks free of pain and with improving strength.

Some patients will inform their physicians that they have experienced "tingling sensations" or "numbness" in their arms or fingers, whereas others will describe weakness. However, usually it is pain that brings them to the doctor's office. The pain is either in the posterior or lateral neck and often radiates between the scapulae or into the shoulder (often attributed to bursitis). Not infrequently it will radiate down the arm and into one or more digits. It may be a dull sickening pain or a sharp, shock-like sensation, usually aggravated by movement of the neck. Only 10% of patients will give a history of antecedent trauma quite unlike lumbar disc ruptures.

During clinical examination the radicular nature of the pain can usually be reproduced by gentle passive flexion, extension, lateral tilting or rotation

of the cervical spine. Additional useful information in diagnosing radiculopathy is gathered from testing of strength and reflexes. The latter is best done with the patient sitting with the arms relaxed on the lap. A decreased biceps or brachioradialis reflex and weakness of elbow flexion denotes a C_6 radiculopathy (C_{5}-$_6$ disc). If in addition there is weakness of shoulder abduction the offending disc is probably at C_{4}-$_5$. A deficient triceps reflex and/or corresponding weakness in elbow extension implicates the C_{6}-$_7$ disc, and if the wrist extensors are also weak the C_7-T_1 disc may have ruptured. Careful testing with a pin for sensory loss and referral to a dermatome chart may corroborate the level in question, but sensory change is less reliable. In a recent series 540 cases out of 548 had findings of localization as described above.[1]

Ruptured discs at C_7-T_1 and T_1-T_2 combined account for 12% of the cases. In this group the presenting complaint may be that of anterior chest and medial arm pain. It is recognized that many of these patients present themselves to the cardiologist. Under such circumstances a neurological evaluation may be indicated should the cardiology workup prove negative.

Plain films of the cervical spine may show narrowing of the disc space in question or reversal of the normal lordotic curve from muscle spasm. In equivocal cases electromyography may indicate denervation of the root in question. Myelography (Fig. 1) then confirms the lesion if surgery is contemplated.

In most instances conservative treatment consisting of a rigid plastic collar for up to six weeks, refraining from heavy lifting (lifting pulls not only upon the shoulder girdle but also the insertion of its stabilizing muscles in the neck), analgesics and intermittent cervical traction will provide relief.

Indications for surgical referral include: an initial severe neurological deficit, progression of neu-



Fig. 1.—Posterior oblique projection during myelogram of case 1. The dark arrow indicates a normal root sheath pouch whereas the open arrow shows the filling defect of an acute disc rupture impinging on the sheath at C_{6}-$_7$.



Fig. 2.—Plain lateral cervical spine film in case 1 three months postoperatively to show solid fusion between C_6 and C_7 (large solid arrow).

rological deficit, failure to improve or worsening of pain (traction may intensify the pain in the presence of a free ruptured disc fragment).

The surgical approach may be either laminectomy and removal of a soft lateral fragment or by the anterior method utilizing interbody fusion (Fig. 2). This varies with the nature of the lesion and the experience of the surgeon. The results of surgery in properly selected patients is gratifying. Eighty four percent of patients will gain 90% to 100% relief of pain.[1]

Cervical Spondylosis

The pathologic substrate in this disease is chronic degeneration of the intervertebral disc, and it usually occurs at multiple levels. Concurrently there is reactive bone formation about the apophyseal joints, the vertebral body margins and the neural foramina, and there is thickening and inbending of the ligamentum flavum. The changes described may not only cause local neck pain but also radicular pain (by compression from foraminal osteophytes), and may cause myelopathy from narrowing of the cervical canal from protruding calcific bars anteriorly and thickened ligaments posteriorly). Plain spine films are of significant value in delineating these changes.

Clinically the physician looks for those signs of radiculopathy alluded to previously. Atrophy and fasciculations may also be evident in advanced cases.

Spondylotic myelopathy may be present with or without concurrent root involvement. Important physical findings in this regard would include: hyperreflexia, weakness in the legs, Babinski's sign, loss of position and vibratory sense in the toes and urinary incontinence. If these signs of spinal cord compression are found prompt neurological referral is in order.

Treatment for pain alone may consist of intermittent traction, cervical collar and mild analgesics. However, in those patients with progressive radiculomyelopathy surgical decompression of the compromised spinal cord and/or nerve roots is indicated.

Differential Diagnosis

1. Spinal tumor. While meningiomas and neurofibromas encompass the majority of benign spinal tumors that are likely to cause radicular compression, metastatic cancer and myeloma make up the majority of malignant tumors.

Plain radiographs, tomography and myelography will generally make the proper diagnosis in most of these cases. Treatment is primarily surgical for tumor removal and decompression of neural structures. Cobalt and chemotherapy are used when indicated.

2. Cervical rib. Compression or stretching of the brachial plexus and subclavian vessels may be caused by a cervical rib, producing arm pain with or without neurological deficit or vascular changes. A positive Adson's maneuver (obliteration of the radial pulse of the outstretched arm produced by rotation of the head in the opposite direction) should prompt the physician to check for a cervical rib on x-ray. This maneuver can also be positive with a thoracic outlet syndrome. The treatment consists of removing the cervical rib if the symptoms are severe or intractable.

3. Thoracic outlet syndrome. Some people, particularly females, possess a narrow thoracic outlet angle, and the brachial plexus and subclavian vessels are stretched over the first rib. Venous distention of the hand and arm when held above the level of the heart and a positive Adson's maneuver are the usual physical findings in this condition. Mild cases respond to shoulder shrugging exercises, whereas severe cases require resection of the first thoracic rib.

4. Pancoast or superior sulcus tumors, generally bronchogenic carcinoma, frequently extend into the brachial plexus and may present with pain, numbness and weakness of the arm. Whereas neck and interscapular pain is generally absent. Horner's syndrome is commonly present. Chest x-rays may be negative early during the course of the disease, and tomography, though generally diagnostic, may miss an early lesion. Repeat radiographs may be indicated if other causes are not found.

5. Carpal tunnel syndrome is a peripheral nerve entrapment that is a particularly common and important cause of upper extremity pain. The median nerve is compressed beneath the transverse carpal ligament at the wrist.

Although it was formerly thought that this syndrome would not cause pain proximal to the distal forearm, it has become evident that pain may be present in the entire arm, shoulder and occasionally the neck. The pain is aggravated by using the hand and classically awakens the patient at night. Paresthesias and sensory loss corresponding to the median nerve sensory distribution are often present.

The only weakness or atrophy may be in the abductor pollicis brevis of the thenar eminence. The sine qua non for diagnosis is electromyography and nerve conduction studies, which are extremely sensitive and accurate. The physician should be aware of the frequency of association of the carpal tunnel syndrome with acromegaly, diabetes, hypothyroidism and pregnancy. However, the majority of cases occur in middle-aged women, and are idiopathic. While relief is generally temporary after steroid injection along the median nerve in the carpal tunnel it is usually permanent after surgical decompression. The operation is a minor procedure which may be done easily under local anesthesia and produces good results in 90% of cases.

An important concept relating to the frequent association of peripheral nerve entrapment (i.e. carpal tunnel syndrome) with a proximal root compression at the spinal level (i.e. spondylosis) has been discussed by Upton and McComas.[2] This concept is termed "double crush syndrome" and points out the frequency of coexisting proximal root lesions may be as high as 70% in peripheral entrapments. Failure of peripheral entrapment surgery should lead to evaluation for co-existing spinal lesions.

6. Other entrapment neuropathies, related to Struther's ligament, pronator teres, ulnar groove or involving the anterior or posterior interosseous nerves are less common. These require special investigation, and are beyond the scope of this paper.

7. Vascular occlusion producing arm pain is not generally a problem in the differential diagnosis.

The onset is abrupt and changes in pulse, blood pressure and color of the extremity are quite evident.

8. Causalgia is a pain syndrome resulting from trauma to a major peripheral nerve. This excruciating pain has a "burning" quality and large areas of the limb are extremely sensitive to the touch. Edema and trophic changes are common. Treatment with sympathectomy may be dramatic.

9. Cardiogenic causes of arm pain either from an acute myocardial infarction or from a subsequent "shoulder-hand" syndrome can be a problem in diagnosis. A careful cardiac evaluation should exclude or confirm this as a source of pain.

Conclusion

It should be stressed that the majority of the conditions outlined can be diagnosed by the primary physician utilizing a careful history and evaluation of clinical findings. Roentgenograms, electromyography and other diagnostic procedures will help confirm clinical impressions. Treatment for the majority of these problems is reasonably safe and effective. Intractable pain and disability from loss of motor function or sensory deficit can be avoided or relieved by proper treatment in most cases.

References

1. Murphy, F.; Simmons, J. C. H., and Bruson, B.: Surgical Treatment of Laterally Ruptured Cervical Disc, J. Neurosurg. 38: 679-683, 1973.
2. Upton, A. R. M. and McComas, A. J.: Double Crush in Nerve-Entrapment Syndromes, Lancet 2:359-362, 1973.

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The optimist proclaims that we live in the best of all possible worlds; and the pessimist fears this is true.

James Branch Cabell

Cervical Spondylosis

J. Robert Mozingo, M.D., C. Jin Whang, M.D., Joseph C. Cauthen, M.D., and Warren D. Wilson, M.D.

Abstract: Cervical spondylosis is a normal physiologic degenerative process of aging affecting the structures of the cervical spine. Progressive physiologic desiccation of the cervical intervertebral disc is the basic pathologic process initiating other changes in the structures of the cervical spine. Osteophyte formation across the intervertebral disc space, and the small joints laterally along with hypertrophy of the intraspinal ligament structures and bulging of the intervertebral disc may cause nerve root or spinal cord compression. The lower cervical interspaces are the most common affected with spondylosis. The neurologic complications of cervical spondylosis, as well as the diagnosis and treatment are presented.

Cervical spondylosis is the most common cause of cervical spinal cord compression after age 40. It refers to changes in the structures of the adult cervical spine due to the normal physiologic process of aging. These changes are now recognized as being degenerative in nature and are initiated by progressive dessication of the cervical intervertebral disc with age. The condition is not inflammatory or arthritic in origin and the designation, cervical spondylosis, has replaced such terms as cervical osteoarthritis, spondylitis, hypertrophic osteoarthropathy and herniated disc. Knowledge of cervical spondylosis is important in recognizing the common neurological symptoms and deficits that may result from this aging process.

Incidence

The presence of spondylitic changes increase with age. At ages 30 and 50 years approximately 25% and 50% respectively of the population have the changes apparent on plain radiographs. The incidence is higher in males than females and appears to be higher in those persons experiencing cervical spine trauma such as fractures. The basic changes are recognized as a physiologic degenerative process. Some radiologists have written that the changes are apparent radiographically in all persons past age 35.[1]

Pathology

The basic pathologic process initiating cervical spondylosis is a progressive physiologic dessication of the cervical intervertebral disc. Water content of the intervertebral disc at birth is approximately 80% by weight and decreases to 65%-69% by age 60. With dessication the disc loses resilience and ability to maintain stable configuration with the movements of normal daily activity. The disc loses height and the interspace narrows or appears to collapse on radiographs. These changes cause abnormal motion in the small joints of the spine with a resultant build-up of new bone formation called osteophytes. The osteophytes attempt to bridge the intervertebral disc space anteriorly and posteriorly in addition to occurring at the uncovertebral joints laterally. The changes are most apparent on lateral and oblique views of the cervical spine. There may be concomitant bulging of the intervertebral disc into adjacent neural foramina laterally and into the spinal canal posteriorly. Osteophytic growth coupled with bulging of the intervertebral disc may result in compression of the cervical sensory and motor roots

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Fig. 1.—Lateral view of cervical spine showing typical changes of cervical spondylosis with disc space narrowing and osteophyte formation most prominent at the C5-6 interspace.



Fig. 2.—Preoperative cervical myelogram showing spinal cord compression by thickened and enfolded ligamentum flavum posteriorly and by a large osteophyte anteriorly at the C6-7 interspace.

as they exit the spinal canal through their respective neural foramina or may result in spinal cord compression as the aggregate mass (osteophytes and disc) projects posteriorly. A combination of root and cord compression is not uncommon. There is usually a compensatory thickening and enlargement of the support ligaments, usually the ligamentum flavum, that is an additive factor in cord compression. All these changes are accentuated in the person having a congenitally narrow cervical spinal canal and the anteroposterior width of the canal is a measurement that has to be considered in evaluating a neurologic deficit that may be caused by cervical spondylosis. The minimum sagittal (anteroposterior) diameter of the cervical spinal canal needed for the spinal cord is 13 millimeters. Every patient with a spinal cord deficit, and having a sagittal diameter of the cervical canal of 13 millimeters or less, as measured on lateral plain radiographs, must be considered as having spinal cord compression due to cervical spondylosis. The lower cervical interspaces (C5-6 and C6-7) are most common affected with spondylosis (Fig. 1). Minor degrees of vertebral body subluxation may be apparent and may lead to a mistaken diagnosis of a "fracture" of the cervical spine.

Symptoms

The neurological symptoms of cervical spondylosis are related to cervical nerve root or spinal cord compression or a combination of both. Neck pain is usually not a major complaint although minor degrees of pain may be uncovered with questioning. Cervical nerve root compression (radiculopathy) is manifested by sensations of numbness and dull or sharp radiating pain in the dermatome supplied by the affected root in the upper extremity. Weakness and later atrophy of those muscles supplied by the



Fig. 3.—Postoperative lateral view of anterior cervical discectomy and interbody fusion at the C5-6 interspace (same patient as Fig. 1) showing increased height of the interspace achieved and removal of the osteophytes on posterior margin of the C5 and C6 vertebral bodies (Smith-Robinson techniques).



Fig. 4.—Interim cervical myelogram (after C3-7 laminectomy and prior to anterior approach to remove large osteophyte at C6-7) showing increased space for spinal cord. Same patient as in Fig. 2.

affected root will occur. A thorough knowledge of sensory dermatomes and muscle innervation (by nerve root and peripheral nerve) is required in accurately concluding which nerve root is involved. The radicular symptoms may be in one or both arms.

Spinal cord compression (myelopathy) may occur insidiously over months or years or may be subacutely progressive over weeks to months. Cord compression may be precipitated suddenly by an acute traumatic hyperextension of the cervical spine in patients with cervical spondylosis (as in the patient falling and striking the face or forehead, who then notices weakness or paralysis of the extremities). An insidious onset of cord compression is more commonly seen and is expressed by the patient as a tiredness, weakness or easy fatigue in the lower extremities or tightness of the lower extremities. Atrophy of intrinsic hand muscles is also a common manifestation and is thought to be due to decreased blood supply to the lower cervical cord segments associated with cord compression. On examination one finds hyper-reflexia, increased muscle tone (as tested by resistance to passive muscle stretching) and weakness that is more prominent in proximal lower extremity muscles and in the intrinsic hand muscles.

Diagnosis

Symptomatic cervical spondylosis should be considered in any patient past age 30 with an unexplained neurologic deficit localized below the level of the foramen magnum.[2] Definitive diagnosis is

based on neurological examination and myelographic findings of nerve root sleeve or spinal cord compression with or without a "block" to flow of Pantopaque (Fig. 2). The sagittal diameter of the Pantopaque column is important in determining the significance of myelographic defects.

Treatment

Two treatment methods are available for radicular symptoms—conservative treatment with a soft collar and intermittent cervical traction using 5-7 pounds of weight several times a day. Remission of subjective complaints is usually the case. Surgery has proven to be very beneficial in patients with persistent or recurrent radicular symptoms. Anterior cervical discectomy and osteophytectomy with or without interbody fusion is presently the procedure of choice in patients with radiculopathy who do not respond to conservative treatment (Fig. 3). Good results are achieved in greater than 90% of these patients.

For spinal cord compression, surgery is the only treatment available and is usually a total laminectomy from C2-C7, (Fig. 4), but selected patients may be treated by multiple level discectomy anteriorly. Results are encouraging with 70% improved, 30% stable and in most series no patient made worse after decompression for myelopathy due to cervical spondylosis.

Summary

Cervical spondylosis is a physiologic degenerative process of the cervical spine. The incidence increases with age. Neck pain is not a major complaint. Nerve root and spinal cord compression are the neurologic manifestations of spondylosis. Nerve root symptoms characteristically respond to conservative treatment, but tend to recur with passage of time. Surgery for nerve root compression achieves good or excellent results in more than 90% of patients. Spinal cord compression due to spondylosis can only be treated with surgical decompression of the spinal cord with improvement seen in better than 70% of patients.

References

1. Brain, L. and Wilkinson, M.: Cervical Spondylosis, Philadelphia, W. B. Saunders, 1967, 232 pp.
2. Smith B. H.: Cervical Spondylosis and its Neurological Complications, Springfield, Charles C. Thomas, 1968, 231 pp.

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It is through the idealism of youth
that man catches sight of truth,
and in that idealism he possesses
a wealth which he must never
exchange for anything else.

Albert Schweitzer

Traumatic Unilateral Facet Locking in the Cervical Spine

Horace Norrell, M.D.

Abstract: Unilateral facet locking resulting from a flexion-rotation injury to the cervical spine is a commonly overlooked condition. The radiographic, pathological, and clinical aspects of this condition are presented.

Traumatic unilateral facet dislocation with locking (synonymous with unilateral subluxation, unilateral rotary dislocation[1] or hemiluxation[2]) in the lower portion of the cervical spine is a commonly overlooked or misdiagnosed condition. In Braakman's[2] analysis of 37 patients with unilateral facet locking, the diagnosis was delayed in 15 patients for more than two weeks following injury because: (1) symptoms were not severe enough for the patient to seek medical advice, (2) radiographs were not obtained at the time of the original injury or, of greater importance, (3) the abnormality was incorrectly diagnosed or overlooked on the initial radiographic examination. Since the diagnosis of this condition is so frequently missed, and the correct diagnosis can only be made radiographically, it seems appropriate to review the radiographic, pathological and clinical aspects of this abnormality which has not received adequate attention in the American literature.

Pathology

In 1855 Malgaigne,[3] dissecting the spines of victims who had died from spinal injury, carefully differentiated between bilateral facet dislocation (23 cases) and unilateral dislocation (nine cases). He attributed cervical spinal dislocations with bilateral locking to a pure flexion injury and further recognized that to produce unilateral facet locking a rotational as well as a flexion force was necessary. Malgaigne's description of the ligamentous injury accompanying unilateral facet locking was confirmed 100 years later by the experiments of Beatson[4] who demonstrated that the facet joint could be dislocated and locked unilaterally only if the interspinous ligament and joint capsule were completely ruptured on the dislocated side. Beatson further showed that unilateral facet locking could occur with minimal damage to the anulus fibrosus and the posterior longitudinal ligament in the region of the uncovertebral joint of the dislocated side, indicating a rather localized ligamentous injury about the facet joint.

Radiographic Features

The radiographic features of unilateral facet



Fig. 1.—Radiopaque markers have been fixed to the superior and inferior articular surfaces of the unilaterally locked facets in the reconstructed desiccated cervical spine.

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Fig. 2.—There is unilateral locking of the articular facets between the fourth and fifth cervical vertebrae.



Fig. 3.—Unilateral locking of the articular facets between the fourth and fifth cervical vertebrae was not appreciated during the initial interpretation of this radiograph. There is an apparent absence of vertebral body displacement in the lateral projection radiograph. A fracture of the trailing edge of the inferior articular facet results in less rotation (and body displacement) than is seen with intact facets; the arrangement of the facets is characteristic of unilateral facet dislocation.

locking are quite characteristic. In the anteroposterior projection the rotation of the entire spinal segment above the level of the locking cause the spinous processes to be rotated to the side of the locking. Whereas, below the level of the locking the spinous processes remain in the midline. Also, the superior vertebral body at the level of locking may be inclined toward the side of the locked facet.

In the lateral projection (Figs. 1 and 2), the vertebral column below the level of unilateral facet locking is properly positioned, while above the level of locking the entire column is obliquely rotated. In the upper rotated segment all of the facet joints on the side of the locking are seen projected through the vertebral bodies, while on the opposite side the facets remain in a more normal position. There is also an apparent reduction in the distance between the posterior margins of the articular facets and the origin of the spinous processes (the laminal segment) in the cephalic rotated segment of the spine. Previous publications have stressed the extent of vertebral body subluxation at the level of the facet locking. The degree of subluxation is always less than one half of the width of the vertebral body, but if the trailing edge of the involved inferior articular facet is fractured or if the overriding is incomplete, the subluxation may be negligible (Fig. 3).

In the oblique radiographic projection demonstrating the facets on the side of the locking the vertebral body subluxation causes an interruption of the spinal canal boundaries and the facet overriding is readily apparent. On the opposite oblique projection the vertebral alignment and facets appear normal (Fig. 4). In addition to the facet locking, fractures of the superior and/or inferior articular facets or the lower vertebral body may be seen.

Incidence of Unilateral Facet Locking

In an analysis of 335 cases of injury to the lower cervical spine (excluding the atlas and axis) from three neurosurgical centers in Holland, Braakman[5] found unilateral locking of the articular facets in 50 patients (15%), identical to the number of cases

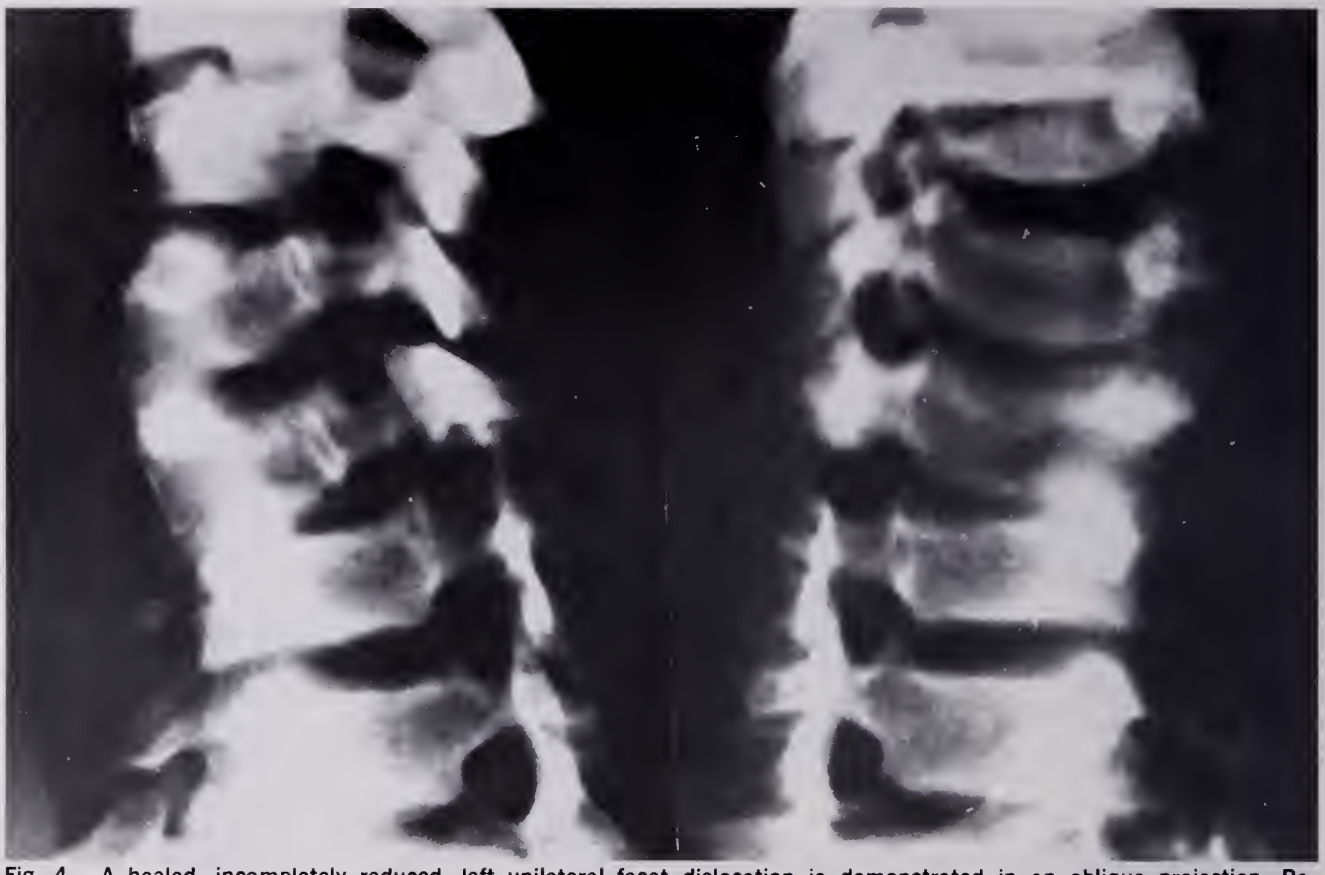


Fig. 4.—A healed, incompletely reduced, left unilateral facet dislocation is demonstrated in an oblique projection. Radiographs were not obtained at the time of the original injury. The facets have been fractured on the left side of the fourth cervical vertebra. (4A) The subluxation of the fourth vertebral body is striking, while on the opposite oblique projection (4B) there is no subluxation.

of dislocation with bilateral facet locking. Rogers[6] found unilateral facet locking occurred only nine times in 66 injuries to the lower cervical spine. In the University of Kentucky series (author's cases) of 142 major injuries to the lower cervical spine (1964-1972), unilateral facet locking was found in only nine cases. There has been one case of unilateral facet locking seen at Sarasota Memorial Hospital in the past two years. Bilateral locking, likewise, was also much less common than reported in Braakman's series, whereas burst fractures of the vertebral body were much more common in the Kentucky series. This discrepancy is difficult to explain, unless the forces producing the injury were greater in the Kentucky series. Many of Braakman's cases resulted from falls, whereas the majority of the fractures and dislocations in the Kentucky series resulted from automobile accidents.

Clinical Features

Unilateral facet locking results from a flexion-rotation injury to the cervical spine. The force is usually applied to the side of the head or face and transmitted to the vertebral axis. Relatively minor trauma may result in unilateral facet locking and neck symptoms may be minimal. The spinal cord escaped injury in 31 of Braakman's 50 patients with unilateral facet locking, while complete spinal cord transection occurred in only five cases (10%); in contrast, 50% of the patients with bilateral facet locking suffered spinal cord transection. With unilateral facet locking there is only a minimal reduction in the sagittal diameter of the spinal canal, hence the incidence of serious spinal cord injury is low, whereas, with bilateral facet locking the sagittal diameter is markedly reduced and the spinal cord injury is more frequent and severe (Fig. 5). Spinal cord injury when it does occur with unilateral locking is frequently limited to the side of the locked facets producing a Brown-Sequard Syndrome. Injury to the nerve root at the site of the facet locking is common from impingement of the overriding inferior articular facet on the nerve root as it exists through the intervertebral foramen.

Reduction of the locking usually results in recovery of nerve root function. If the unilateral

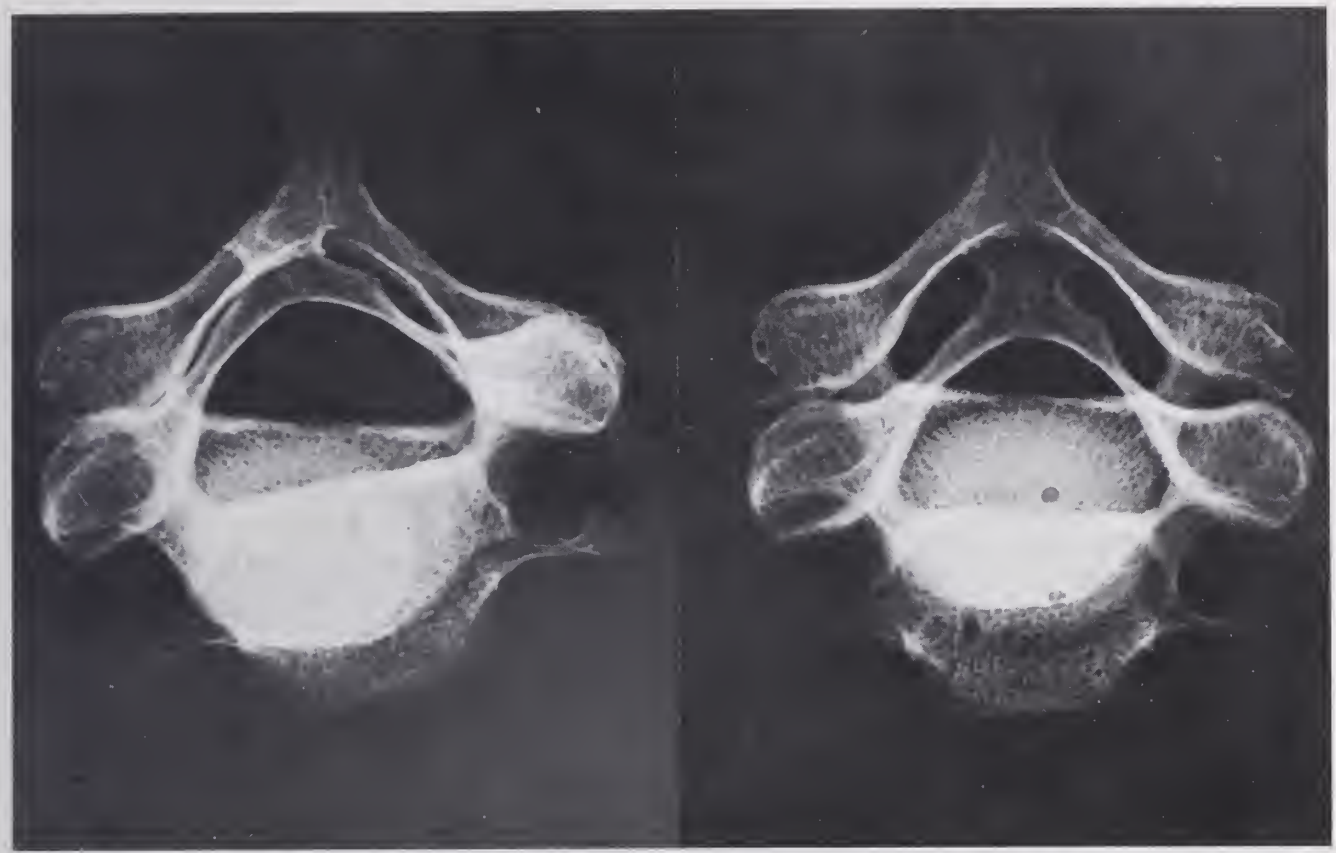


Fig. 5.—Two adjacent cervical vertebrae are used to demonstrate the reduction in the sagittal diameter of the spinal canal with unilateral facet locking. (5A) When compared with complete dislocation with bilateral facet locking (5B).

locking is recognized early, within 14 days of injury, reduction may be accomplished by tong traction. Braakman emphasizes that sufficient weight on the tongs (greater than 10 kg) is usually necessary to achieve reduction. He used manipulative reduction under general anesthesia in many of his cases, a procedure generally not accepted in the United States. Manipulative reduction can usually be accomplished with the patient awake. With tong traction and under fluoroscopic image intensification, increased tension is placed upon the tongs with the head in flexion and rotated away from the side of the locking. The relationship between the trailing edge of the inferior articular facet and the leading edge of the superior articular facet is carefully monitored. It may be necessary to increase the tong traction pull up to 75 pounds and forcefully flex and turn the head. A perceptible snap may be heard or felt as the facets relocate. When this occurs the traction is immediately reduced, the head returned to the midline and the flexion corrected. If during the course of the reduction any symptoms or signs of spinal cord compression develop, the manipulation is ended. Commonly the cervical radicular pain is much worse during manipulation but following reduction the pain disappears. No complications have been encountered in using this technique in four patients with unilateral facet locking, nor have I failed to reduce a unilateral locked facet using this maneuver. Following closed reduction the patient should be maintained in tong traction or immobilized in a halo apparatus for at least six weeks. If closed reduction fails, then open reduction through a posterior approach is easily accomplished by removing the leading edge of the locked superior articular facet; this should be accompanied by a spine fusion. If the locking is more than two months old it is probably best left alone since open or closed reduction is only rarely successful.

References

1. Whitley, J. F. and Forsyth, H. F.: Classification of Cervical Spine Injuries, Am. J. Roentgen. 83: 633-644 (April) 1960.
2. Braakman, R. and Vinken, P. J.: Unilateral Facet Interlocking in Lower Cervical Spine, J. Bone Joint Surg. (Brit.) 49:249-257 (May) 1967.
3. Malgaigne, J. F.: Traite des fractures et des luxations. Tome 2, Des Luxations. Paris, J. B. Bailliere, 1855, pp. 356-381.
4. Beatson, T. R.: Fracture Dislocations of Cervical Spine, J. Bone Joint Surg. (Brit.) 45:21-35 (Feb.) 1963.
5. Braakman, R. and Penning, L.: Injuries of Cervical Spine, Amsterdam, Excerpta Medica 1971, pp. 161-183.
6. Rogers, W. A.: Fractures and Dislocations of Cervical Spine, J. Bone Joint Surg. (Amer.) 39:34-376 (April) 1957.

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Bony Encroachment of the Lumbar Spine A Cause of Low Back Surgery Failure

Hubert L. Rosomoff, M.D.

Abstract: Transaxial lumbar tomography has made possible detection of heretofore undetected bony encroachment into the lumbar spine. Accompanying this development was evolution of the operation of dorsal arch resection.

A series of 100 patients have been investigated; 31 ultimately came to surgery. Their clinical profile includes back and lower extremity pain of non-radicular nature, dysesthesiae, minimal neurological deficits, but multiple reflex changes. Radiologically there is evidence of multiple levels of bony involvement. EMG demonstrates multiple radiculopathies at one or more levels. Myelography may demonstrate the bony defect if careful analysis is made but generally is not outstandingly abnormal.

Dorsal arch resection in 31 totally disabled patients resulted in seven returning to full activity, six remaining totally disabled, and 18 having reached degrees of limited activity considered to be a major improvement from their preoperative state. This preliminary report gives hope of providing a mode of management for patients totally disabled from heretofore undiscovered pathology of the lumbar spine.

Recently the focus of attention concerning compressive syndromes in the lumbar spine has shifted from the intervertebral disc, as the causative agent, to encroachment by the bony integument. The development of the technique for transaxial lumbar tomography has provided further objective evidence supporting the concept of bony disease as a major component of lumbar spine pathology.[1,2] This should have been inferred all along, since the intervertebral disc represents only 25% of the potential area available to produce symptoms, whereas the remaining 75%, which is bony, is a far more likely statistical candidate, starting with congenital anomalies, advancing onto several forms of acquired disease. By far the most common bony problem is the changing position of the inferior and superior articular appendages with advancing age. Since this is a change that is progressive through life from birth, the inference should not be that advanced age is necessary for the presence of pathology. Consider that there are two shifts which occur dynamically with time. One is the moving upward of the superior facet toward the position inferior to the exiting nerve root above it (Fig. 1). The other is the movement medially by the inferior articulation narrowing the canal while enlarging downward toward the floor (Fig. 2). The latter may even trap a nerve root behind it where it cannot be visualized without removal of the facet. In effect the enlarging facet acts as one arm of a pincer, compressing the nerve root between the bone and the

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Fig. 1.—Arrow points to subluxation cephalad of the superior articulation of the L5-S1 joint.

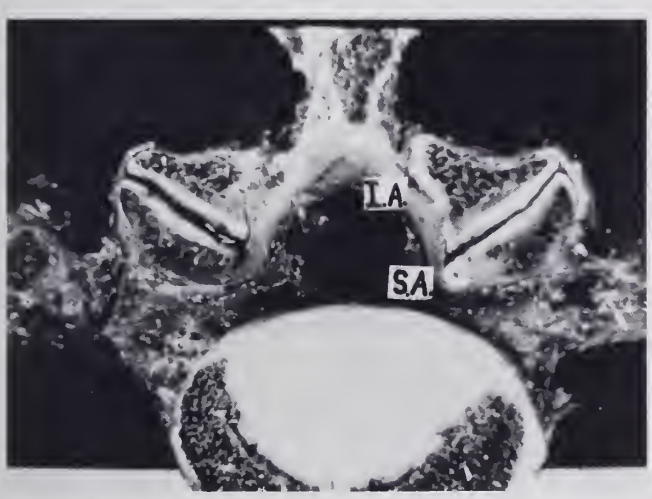


Fig. 2.—Cross-section of lumbar spine. I.A. represents inferior articulation of the facet which may slip from this normal position medially into the spinal canal with advancing age. S.A. represents the superior articulation which, in this specimen, is showing hypertrophic change at its medial margin, another source of encroachment.

area underlying, which is often the intervertebral disc itself (Fig. 3). This pincer action can occur with or without frank protrusion of the intervertebral disc (Fig. 4). In concept, correction only requires

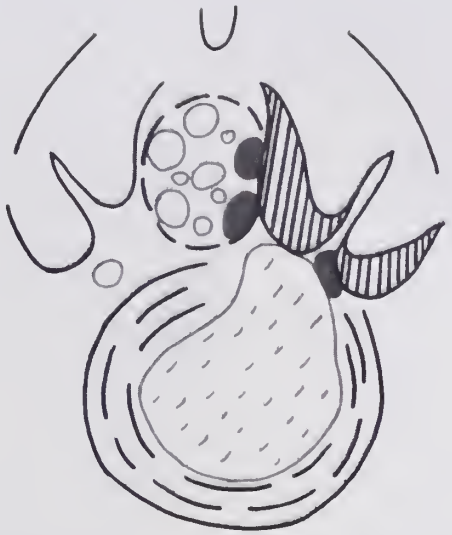


Fig. 3.—Illustration of the pincer action from the hypertrophied facet dorsally (hatched area) and a protruding intervertebral disc ventrally.



Fig. 4.—Illustration of nerve root compression from facetal hypertrophy alone without disc protrusion.

the removal of one arm of the pincer whether it be the bony side on the one hand or the intervertebral disc on the other. Unfortunately many individuals have combinations of both actions so that removal of the soft intervertebral disc alone is not sufficient to relieve all of the compressive elements. In fact, a more complete correction may be achieved in many individuals by removing only the bony covering of the root while leaving the disc intact.

Before development of the technique for transaxial lumbar tomography, there was no good and consistent way to demonstrate objectively encroachment into the spinal canal by the bony elements.[3] With use of this technique, however, it has become clear that many individuals, particularly those who have been failures for intervertebral disc removal, have bony encroachment as the major element of their nerve root compressive syndrome. As such, in this Medical Center all patients being evaluated for lumbar root disease have axial tomograms as a necessary component of their study. Lumbar surgery is not undertaken without having axial tomograms for the planning of surgery. It would be foolhardy to remove a protruding disc when, in fact, the causative element of compression is bony overgrowth from the facet.

When bony encroachment from the facets, an abnormal dorsal arch, or ingrowth from an overlying fusion can be established, the procedure required for treatment is a dorsal arch resection. This may be necessary at multiple levels depending on the areas of pathological involvement. The operation includes the standard laminectomy with removal of the spinous process and laminae and total removal of both inferior and superior articular appendages bilaterally in order to leave entirely free and mobile the nerve roots exiting on both sides at the given spinal level (Fig. 5).

Clinical Material

During the past three years over 100 patients have been evaluated, among which 31 patients have qualified for the procedure of dorsal arch resection. More than two thirds were in the fifth and sixth decades of life or older and there was a slight preponderance of female over male. The incidence of the older age group should immediately warn that symptoms in such patients are not the expression of intervertebral disc herniation, which is more commonly a disease of the younger population, but rather another problem producing nerve root compression not originating from the disc space itself. Moreover, when the length of the history presented by the patient is reviewed, two thirds of the patients have histories that date beyond two years, and only seven patients were seen within six months of the origin of their symptomatology. This, too, should indicate the chronicity of the problem. As indicated previously, the procedure was first proposed for individuals who had previous surgery with failure. In the group of patients with previous surgeries, at least three had four operations and over half had more than one. Although dorsal arch resection was applied originally as "salvage back surgery," it is now clear that there is a place for this type of management in initial definitive treatment of previously unoperated backs.

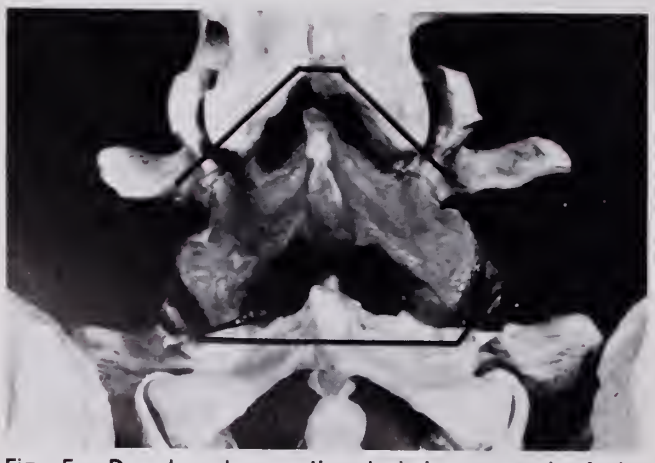


Fig. 5.—Dorsal arch resection includes removal of the depicted (dark) area: spinous process, laminae and the inferior and superior appendages of the joints bilaterally.

Although bilateral pathology is the rule at multiple levels, the complaint of pain with which all presented was only bilateral in one third of the patients. Unilateral complaints were offered most often in both the back and leg and, the majority of individuals complained of pain which was nonradicular in type, in contradistinction to the usual major radicular extension with acutely herniated discs.

Neurological symptoms were present but were not impressive. Again, one third were bilateral in distribution; the remaining were unilateral and primarily in a sensory sphere, complaining of either numbness or dysesthesia. The neurological examination demonstrated more bilaterality than suggested by the presenting symptoms. This was particularly true in respect to the reflex examination and, importantly so, when combined with the sensory and motor components.

Mechanical signs of root compression were absent in one third of the patients, again, an uncommon finding with acute herniations. Sciatic stretch tests were positive in the majority, but, interestingly, limitation of motion in the back was not a major presentation. The patients could move their backs well despite the fact that they became symptomatic when the sciatic nerve was put to the stretch.

Electromyographic findings demonstrated bilaterality in one third of the patients and multiple levels of involvement; although, interestingly, normal examinations were found despite major complaints of pain which disabled the patient.



Fig. 6.—Oblique view, standard lumbosacral radiographs. Note cephalad subluxation of the superior articulation of the facet.



Fig. 7.—Oblique view, myelogram, demonstrating a ventral defect from a hypertrophied facet (right) as well as a dorsal imprint from the opposite facet (left).

A careful review of the lumbosacral radiographs could provide the necessary information to suspect the diagnosis. However, lumbar roentgenograms are not usually viewed for facetal hypertrophy or the "small canal." Unless the radiologist and surgeon are looking for bony changes, they will not be noted in the routine report (Fig. 6). The definitive examination is the transaxial tomogram and this remains the most useful tool in making the appropriate diagnosis. An important clue in the standard lumbosacral roentgenograms is the multiplicity of the levels of involvement, particularly when taken in context with bilaterality and multiplicity of presenting symptoms, signs and electromyographic findings. All individuals who came to dorsal arch resection were found to be positive on the axial tomograms; the majority had facetal hypertrophy. Acquired stenosis was not uncommon, although congenital stenoses were seen as well. Ingrowth of fusions was also common, but the important clue was that 75% of the patients had multiple levels of involvement.

When myelography is added to the diagnostic battery, and when dorsal defects were sought, they could be demonstrated and correlated with the abnormalities on the axial tomograms. While the multiplicity of involvement was even more manifest on myelography, many of the ventral defects were, in fact, bony in origin from ingrowth of the leading edge of the articular appendage. These defects had been originally interpreted as being disc protrusions and this has been the major source of false diagnoses, leading to disc removal rather than bony extirpation (Fig. 7).

Results

All patients who came to dorsal arch resection had been treated conservatively for long periods of time and most did represent a failure for previous back surgeries. With the full display of diagnostic tests, it was possible to plan surgery which was, necessarily, dorsal arch resections at all levels of proved involvement. As a consequence of the multiplicity, double and triple arch resections were often

required, single arch resection being the more unusual procedure. Where bony encroachment was clearly demonstrated, even in the presence of disc protrusion, but without frank breaching of the annulus and extrusion of disc fragments, the bone was removed without violation of the intervertebral disc itself.

Complications of this surgery were small in number. The immediate question to be raised is stability of the spine after its bony integument has been removed. It would appear that the major stabilizing tissue in the lumbar spine is the attachment of the annulus pulposus; bony stabilization, by way of fusion, is not required. In three years there has been only one incidence of subluxation, this in a young lady who had had multiple disc space operations and in whom the annulus pulposus had completely disintegrated. Without any retaining structure of strength, she did sublux, but has remained in a stable position without a superimposed fusion procedure. One neurological deficit has been incurred during surgery; this was a unilateral foot drop which has since recovered. There was one complicating intraspinal hematoma in a patient who had been placed on anticoagulants for a pulmonary embolus. There were two instances of indwelling catheters for prolonged periods; however, no patient eventually came to permanent catheterization. This is most heartening if it is remembered that at least 85% of individuals with lumbar root syndromes may have clinically silent neurogenic bladders.[4]

The results of this form of surgery, ranging in time of follow-up from three months to three years, indicate a gratifying degree of improvement. All patients in this group of 31 patients were totally disabled prior to surgical intervention. As of this date, seven have returned to full activity, six remain disabled, and 18 have limited degrees of activity but clear improvement over their preoperative status. For a problem as discouraging as the "failed low back," the results are hopeful indeed. Of course, longer periods of time must transpire before a final evaluation of the dorsal arch resection in the surgical armamentarium can be defined. But, there seems to be a clear role for this procedure in individuals where bony encroachment can be demonstrated objectively and all the corroborating circumstances of history, examination and diagnostic tests support the conclusion that bony encroachment is the major element of the patient's problem.

Summary and Conclusions

A group of 31 totally disabled patients has been studied for the role of bony encroachments in the production of symptoms referable to the lumbar spine. Particularly, patients who have been previous failures for low back surgery have been shown to have bony encroachment as a major element of their root compressive syndromes. The optimu test for demonstrating objectively the presence of bony disease is the transaxial tomogram. When this test is supported by the other corraborating findings in the evaluation regimen, the procedure of dorsal arch resection has been carried out for treatment of the problem. The results of dorsal arch resection, an operation more extensive than standard laminectomy and disc removal, have been gratifying with the return to full activity of seven patients, another 18 patients to limited forms of activity, while six remain in their disabled state. It is hoped that the latter group will transfer to increased activity with the passage of time.

It is concluded that dorsal arch resection has a role in the salvage of previous failures for lumbar spine surgery; the procedure also has a role in the treatment of unoperated spines when bony encroachment can clearly be demonstrated by objective techniques.

References

1. Jacobson, R. E.; Gargano, F. P., and Rosomoff, H.L.: Transverse Axial Tomography of the Spine. Part 1: Axial Anatomy of the Normal Lumbar Spine, J. Neurosurg. 42:406-411 (April) 1975.
2. Jacobson, R. E.; Gargano, F. P., and Rosomoff, H. L.: Transverse Axial Tomography of the Spine. Part 2: The Stenotic Spinal Canal, J. Neurosurg. 42:412-419, (April) 1975.
3. Gargano, F. P.; Jacobson, R. E., and Rosomoff, H. L.: Transverse Axial Tomography of the Spine, Neuroradiology 6:254-258. 1974.
4. Rosomoff, H. L.; Johnston, J. D. H.; Gallo, A. E.; Ludmer, M.; Givens, F T.; Carney, F T., and Kuehn, C. A.: Cystometry as an Adjunct in the Evaluation of Lumbar Disc Syndromes, J. Neurosurg. 33:67-74, 1970.

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Fortitude is the marshal of thought, the armor of the will and the fort of reason.

Bacon

Chronic Spinal Radiculopathy With Particular Reference to Spinal Arachnoiditis A Surgical Viewpoint

A. W. Auld, M.D.

Abstract: Twenty-eight patients with chronic spinal radiculopathy have been reviewed. Most had reached the intractable level of their disease. The diagnosis of chronic spinal arachnoiditis was documented in 16 and highly suspect in 12. Decompressive surgery offers very little to these patients unless they are bedridden, have significant motor deficit or loss of bladder function. In these cases, surgery was of some benefit in over one half.

Interesting features were found in this study: (1) Normal myelograms can be seen in patients with extensive arachnoiditis. (2) A postoperative syndrome was seen in a retrospective study of the patients' previous surgeries. It was noted that eight patients had violent leg spasms, fever, chills and muscle cramps in the immediate postoperative period. This syndrome usually lasted a few days to several weeks. Later, and sometimes years later, the syndrome of chronic spinal arachnoiditis became apparent.

Physicians dealing with chronic pain problems invariably encounter patients with so-called "chronic spinal radiculopathy syndrome." This discouraging and often intractable syndrome is a common initial diagnosis for a multitude of diseases that present with radicular signs and symptoms.[1] Definitive diagnosis will usually establish a cause but in some patients origin of the disease remains obscure.[2-4] Some of the known causes would include bony abnormalities, various neuropathies, discogenic diseases, and may be seen following trauma, infection, spinal surgery, spinal anesthesia, myelography and a host of other disorders.[1-4] A prominent member of this syndrome is chronic spinal arachnoiditis[5] and is the major interest of this report. The signs and symptoms of this entity are well known.[1,6-9]

Twenty-eight patients who presented with intractable pain and various neurological findings are reviewed in detail.

Clinical Material and Methods

Almost all the patients in this series were referred for some type of pain relieving procedures (cordotomy, etc.) or further spinal surgery. They had failed to respond to any type of treatment including prior surgical procedures, physical therapy, steroids and the usual methods of conservative therapy. Some of the patients had had a trial of transcutaneous stimulation, facet rhizotomy and percutaneous cordotomies. The cases in this series were from a large general population of the southeastern United States. Almost twice the number of males as females were seen and more than one half the patients were over 50 years of age.

Twenty-four patients (84%) were incapacitated from work or other activity. All of the patients had radicular pain. Thirty percent (nine patients) were moderately to severely incapacitated by neurological deficits involving their lower extremities. Five patients had bladder disturbances (18%) (Table 1).

Twenty-three patients had one or more surgical procedures for herniated disc from nine months to five years before. Three patients had only myelography in the past.

The diagnosis of chronic spinal arachnoiditis was established at surgery in 16 patients while in the remaining 12 the diagnosis was suspected but not verified. The lumbar area was involved in all of the patients except one. That patient had thoracic arachnolditis of unknown origin.

In the 16 cases in which the diagnosis of arachnoiditis was proven at surgery, it was interesting to note that three patients had normal myelograms (Table 2). Smith[10] reported fairly normal myelograms in patients with arachnoiditis showing only small lateral defects in four patients. He suggested immobilization of the roots against the dura, thus

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allowing the central portion of the subarachnoid space open. Two of the three patients with documented arachnoiditis and with normal myelograms in this series had not had prior surgery or myelography. No obvious cause of their arachnoiditis was ever found. In this group of patients the neural elements were so bound together that the entire area of arachnoiditis made the cauda equina one solid structure centrally, thus allowing the undisturbed flow of Pantopaque around it.

Of the 23 patients who had prior operative procedures for herniated disc disease, all had limited (hemilaminectomies) epidural approaches. It seemed reasonable, before any aggressive pain relieving procedures be contemplated, that any possibility of relieving the source of the pain should be considered for the following reasons: (1) Any other pathological conditions should be excluded with certainty, such as tumors, extruded or herniated discs, and narrow canal or spondylosis. (2) Since no patient in this series had had complete decompressive surgery, it seemed appropriate to decompress the epidural spaces of scar and encroaching bony structures to allow for the further expansion of the subarachnoid spaces (particularly when the dura was opened).

Table 1.—Degree of Impairment by Pain and or Neurological Deficit.

	Number Cases	
Grade	Pain	Motor Deficit
0		9
1	0	10
2	4	5
3	11	3
4	13	1
Total	28	28
Bladder Dysfunction		5

Explanation of grading:

Pain

Grade 1—mild radicular pain.
Grade 2—moderate pain causing loss of time or interference with work or activity.
Grade 3—severe pain, unable to work or engage in useful activity.
Grade 4—bedridden.

Motor

Grade 0—no motor loss.
Grade 1—mild motor loss.
Grade 2—moderate motor loss.
Grade 3—severe motor loss—unable to stand or walk without help.
Grade 4—complete paralysis of one or both legs.

Table 2.—Diagnosis of Spinal Arachnoiditis in 28 Patients With Chronic Spinal Radiculopathy Syndrome.

Diagnosis	Number Cases
Documented at surgery	16
Typical myelogram*	11
Abnormal myelogram not necessarily suggestive of arachnoiditis but strong clinical suspicion	13

*Typical myelograms in this group included complete blocks, incomplete blocks, candle dripping effect, etc.

Surgical Procedures and Results

The decompressive laminectomy was extended as far laterally as possible at the clinical level and one or two levels above or below. Thus in all cases at least two levels were decompressed. Foramenotomies were done with epidural dissection to allow for visualization of the roots and their bony relationships. An extensive search throughout the epidural spaces for missed pathology or significant adhesions was carried out. The dura was opened without disturbing the arachnoid in 16 cases and extensive arachnoiditis was found in all of these patients. Two patients had an extruded disc and another had a significant herniation. In these three cases, multiple prior surgeries had made this an unsuspected finding. The myelograms did not suggest a basic defect and only showed extensive arachnoiditis. Although all three of these patients made an excellent recovery and were pain free for 12 to 18 months, the pain gradually returned to the preoperative level in two patients and a moderate return of pain in the other. Two patients, not included in this series, had typical myelograms of arachnoiditis and past epidural surgical procedures for herniated disc disease. An arteriovenous malformation was found in one and an ependymoma in the other.

The clinical diagnosis of arachnoiditis was confirmed in 16 and suspected in 12. The myelograms of these 12 patients were all abnormal (Table 2) but not necessarily suggestive of arachnoiditis in nine. Half of the 16 cases of documented arachnoiditis showed typical myelographic pictures of that disease (Table 3).

Tables 4 and 5 summarize the surgical results of this series in 28 patients. Table 4 includes those patients who were followed more than eight months but less than one year. Twenty out of the 28 patients were followed for more than two years (Table 5). Excellent or good relief of pain was seen in 15 patients (54%) who were followed for less than one year. Eight patients (29%) showed no improvement while two patients had some relief of pain. The results were much different when the patients were followed for more than two years (Table 5). Of the 20 patients with two year follow-up, only three patients (15%) would be considered as having good relief of pain. The remaining 17 patients

Table 3.—Myelographic Findings In 16 Surgically Documented Cases of Arachnoiditis.

Myelogram	Number Cases
Normal	3
Multiple defects	5
Large defects; candle dripping, worm-like, etc.	1
Incomplete block	1
Complete block	6
Total	16

Table 4.—Results of Extensive Decompressive Laminectomy of 28 Patients* with Diagnosis of Chronic Arachnoiditis.

ONE YEAR FOLLOW-UP**

Procedure	No Improvement	Worse	Fair	Good	Excellent	Total
Dura opened	6	1	0	3	6	16
Dura not opened	2	1	2	4	2	12

*Two patients excluded that had an AVM and ependymoma.

**Four patients were more than eight months but less than one year.

Table 5.—Results of Extensive Decompressive Laminectomy on 20 Patients* with Diagnosis of Chronic Arachnoiditis.

TWO YEAR FOLLOW-UP

Procedure	No Improvement	Worse	Fair	Good	Excellent	Total
Dura opened	9	1	3	0	0	13
Dura not opened	3		1	3	0	7
Total	12	1	4	3	0	20

*Eight patients less than two years or lost to follow-up not included.

had either no improvement or only fair relief of pain. One patient was worse. It appears that only seven patients (35%) had any relief of their pain when long term follow-up was evaluated.

The patients where extruded or significant herniations were detected, in addition to their arachnoiditis, did not fair any better than the other patients with arachnoiditis alone in the long term follow-up.

Several encouraging features were found in this study. Of the five patients with recent (one or two weeks) onset of bladder disturbances, two regained complete control of bladder function despite the gradual return of pain over the next two years following surgery.

Patients with severe motor loss (grades 3 and 4) were evaluated. Two out of the total of four patients in this category had a return of normal function. In grade 2 (five patients), two patients had a return of normal motor function while two remained unchanged, and one patient with thoracic arachnoiditis of unknown cause progressed over several months to complete paraplegia.

Twelve patients were bedridden primarily by pain. Almost half improved after decompressive surgery to some degree. The remaining patients were unchanged and one was worse. It would appear that this procedure was of some benefit in patients who were bedridden, at least initially in some and sustained in others. No patient, however, was completely free of pain.

Complications of a serious nature occurred in one patient who developed staphylococcal meningitis resulting in increased pain for months after surgery.

A postoperative syndrome may signal the onset of chronic spinal arachnoiditis. In reviewing the past surgical procedures in this series, it was noted that eight patients developed a strikingly similar set of symptoms in their immediate postoperative period. This syndrome usually developed in the first 24 hours after surgery and was characterized by violent spasms of the legs (usually bilateral), occasional fever, chills, diaphoresis, and cramps in the legs. The duration of symptoms was usually short lived, never lasting more than several weeks. This syndrome was called a "flu-like illness" in some while in others an interspace infection was suspected but never confirmed. Later, and sometimes years later, the syndrome of painful chronic spinal arachnoiditis was to appear. It may be important to recognized this syndrome as it may be responsive to intrathecal steroids.

It is speculated that this may represent an acute form of arachnoiditis possibly secondary to the blood, residual contrast material (even if present in small amounts) and/or the recent surgical trauma. Howland has reported severe arachnoiditis in dogs when blood and ethyliodophenylundecylate (Pantopaque) are mixed but little reaction to either alone. It is reduced significantly when intrathecal steroids are used.

References

1. White, J. C. and Sweet, W. H.: Pain and the Neurosurgeon: Forty Year Experience, Springfield, Ill., Charles C. Thomas, 1969.
2. Hurteau, E. F.; Baird, W. C., and Sinclair, E. L.: Arachnoiditis Following Use of Iodized Oil, J. Bone Joint Surg. 36:393-400, 1954.
3. Joseph, S. I. and Denson, J. S.: Spinal Anesthetic, Arachnoiditis, and Paraplegia, JAMA 168:1330-1333, 1958.
4. Ransford, A. O.: Localized Archnoiditis Complicating Lumbar Disc Lesions, J. Bone Joint Surg. 54:656-665, 1972.
5. Ramamirthi, B.: Spinal Arachnoiditis, Indian J. Med. Sci. 15:776, 1961.
6. Elkington, J. St. C.: Arachnoiditis, in Feiling, A. (ed): Modern Trends in Neurology, New York, Paul B. Hoeber, 1951.
7. Elkington, J. St. C.: Meningitis Serosa Circumscripta Spinalis (Spinal Arachnoiditis), Brain 59:181-203, 1936.
8. French, J. D.: Clinical Manifestations of Spinal Arachnoiditis; Report of Thirteen Cases, Surgery 20:718-729, 1946.
9. Winkleman, N. W.; Cotten, N., and Scheibert, D.: Localized Adhesive Spinal Arachnoiditis: Study of 25 Cases with Reference to Etiology, Trans. Am. Neurol. A. 78:15-18, 1953.
10. Smith, R. W.: Myelographic Variant in Lumbar Arachnoiditis, J. Neurosurg. 36:441-446, 1972.
11. Howland, W. J. and Curry, J. L.: Pantopaque Arachnoiditis: Experimental Study of Blood as an Attenuating Agent and Corticosteroids as an Ameliorating Agent, Acta. Radiol. (Diagn) Stockholm 5:1032-1041, 1966 ..

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Neurosurgical Care of the Patient With Spina Bifida Aperta

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Abstract: Twenty-two of 24 children with spina bifida aperta received aggressive, multidiscipline management. The two untreated children died within a few days of birth. There was one wound dehiscence. No operative deaths occurred. Two of the 22 actively treated patients died at five and seven months of age. With an average follow-up of 31 months, 11 children have severe to moderate degrees of paraparesis, five have mild neurological deficits in the lower extremities, and four are neurologically normal. Of these 20 survivors, nine are walking without support and at least another three will ultimately ambulate with crutches in lieu of wheel chair. Nine patients (41%) required CSF shunting operations for hydrocephalus.

It is concluded that the decision to treat or not to treat should be carefully individualized to the particular patient. The majority of these children should be vigorously treated. Their defects should be repaired within the first 24 to 48 hours after birth.

The term spina bifida is defined as a cleft of the vertebral column. It is one of the commonest varieties of developmental anomaly. Twenty-five percent of the general population will show some minor defect of a vertebral spine or lamina roentgenographically, without evidence of an external lesion or a neurological deficit. This is spina bifida occulta. If the meninges protrude through the bony defect to form a cystic expansion, the lesion is called a meningocele. Quite often, this cerebrospinal fluid-filled cyst contains nerve roots and/or a portion of the spinal cord, being then termed a myleomeningocele. Myeloschisis describes an exposed neural plate within the spina bifida, without significant meningeal cyst formation. The prefix lipo- is used when an abnormal collection of fatty tissue overlies the meningocele, myelomeningocele, or myeloschisis. These clinically evident anomalies are collectively labeled spina bifida aperta. Their overall incidence in the United States is approximately 2.5 per thousand live births.

The purpose of this paper is to describe the current neurosurgical management of patients with spina bifida aperta at Jackson Memorial Hospital.

Material

All children with unrepaired spina bifida aperta referred to the Division of Pediatric Neurosurgery, University of Miami School of Medicine, over the first 24 months that this method of management was instituted are included in this study.

Method

It is our policy to individualize decisions as to early, late, or no operative repair by careful consideration of the following factors:

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1. Although evaluation of the potential for development of an infant's brain is exceedingly difficult, prematurity, associated illness, and concurrent anomalies are assessed as to their probable effect on long-term mental and societal prognosis, survival, and operative risk.

2. Active hydrocephalus is present in a high percentage of patients with meningomylocele and myeloschisis and is routinely associated with the Arnold-Chiari malformation. Twenty percent of these children can also be shown to have aqueductal stenosis. It is apparent, however, that the IQ range for patients with hydrocephalus in association with spina bifida is higher than that of children with hydrocephalus of other etiologies.

3. The spinal level of the lesion often, but not always, corresponds with the level of physiologic transection. A complete evaluation of the neurological status must be done. Total paraplegia from the D-10 level is incompatible with walking, even with the best orthopedic management.

4. Unepithelialized lesions with or without a frank CSF leak are associated with a significant incidence of meningitis, though many of these children will survive a policy of "watchful neglect". Active medical and surgical management increases their survival rate to 85%.[1]

5. If the lesion is completely epithelialized, an operation at six weeks to three months may be elected. Large or grotesque lesions, however, are best repaired early.

General endotracheal anesthesia is usually preferred, though these lesions should at times be repaired under local anesthesia. Vertical or horizontal incisions heal better than rotated flaps. Using visual magnification, the neural plate and nerve roots are dissected free from adjacent tissues. Dura mater is closed in water-tight fashion over the neural elements, using a freeze-dried dural homograft if necessary. The dura is then covered with another layer of muscle and/or deep fascia. The subcutaneous tissue and skin are closed in layers. Inert, monofilament, plastic sutures are used throughout.

Meticulous wound care includes frequent dressing changes as protection against fecal or urinary contamination, percutaneous needle aspiration of any wound effusion, and intravenous feedings with gradual conversion over several days to small frequent p.o. feedings in order to avoid abdominal distention. Skin sutures are left in for a minimum of ten days.

Orthopedic and urological evaluation and management are begun during the initial admission. These children are then followed in a multidiscipline clinic held monthly at the Mailman Center for Child Development.

Results

Twenty-four patients were evaluated from November 1971 to October 1973. Two infants with multiple additional anomalies were given no definitive treatment and expired within a few days. Of the remaining 22 children, 14 were male, 8 were female, 19 were white, and 3 were black. The levels of spina bifida were as follows: 1 thoracic, 3 thoracolumbar, 9 lumbar, 6 lumbosacral, and 3 sacral. There were 2 meningoceles, 12 myelomeningoceles, 4 myeloschises, and 4 lipomyelomeningoceles. Repair of all 22 lesions was accomplished with no operative mortality, although two children died several months later, one of ventriculitis, and the other of respiratory insufficiency associated with a severe Arnold-Chiari malformation. The only surgical complication consisted of a superficial wound dehiscence which had healed by second intention at the end of the third postoperative week. No patient's neurological status was worse after operative repair.

The average length of follow-up for the entire group is 31 months. Eleven children have severe to moderate degrees of paraparesis, five have mild neurological deficits in the lower extremities, and four are neurologically normal. Of the 20 survivors, nine are walking without support, and at least another three will ultimately ambulate with crutches in lieu of wheel chair. Active hydrocephalus was diagnosed and treated with CSF shunting procedures in nine children. Two posterior fossa decompressions of Arnold Chiari malformations were necessary.

Discussion

We withheld active treatment from only two children. It might be argued that the two who eventually died, despite vigorous support, should not have been treated. Each of these children had a large thoracolumbar myelomeningocele and hydrocephalus. However, we have several patients with comparable anomalies who are attending regular school classes and walk with braces and crutches. The decision to treat or not to treat can be extremely complex and is a most fundamental aspect in the management of these patients. Frank communication should remain open among obstetrician, pediatrician, surgeon, and parents so that a clear under-

standing of the initial and subsequent management are clearly understood by all. These decisions should be individualized to the particular patient rather than based on dogma or emotional bias.

Lipomyelomeningocele repair has been said to be hazardous.[2] A clear understanding of the anatomy of these lesions[3] and use of the operating microscope have made removal of the fat, with decompression and untethering of the spinal cord, a safe procedure. Our experience with these four cases and four additional ones not included in this report have been most gratifying.

Forty-one percent of these children developed active hydrocephalus. If, since lipomyelomeningoceles are not ordinarily associated with hydrocephalus, these four cases are discarded, our incidence of shunted patients is still 50%, versus the 80% cited by some authors.[4] This may be partially explained by a description of our indications for hydrocephalic shunting operations. The anatomical demonstration of large ventricles is established by pneumography or CAT scan. The physiological diagnosis of progressive hydrocephalus is established by serial head circumference measurements that plot a curve that cuts across the 97th percentile line for age. The head growth curve may occasionally fail to reflect increasing ventricular size, so that repeated studies may be required to establish or rule out progressive ventriculomegaly. When shunt operations are carried out under less stringent criteria, many children are later found to be "shunt independent." We do not think that CSF shunting can favorably affect the etiology of hydrocephalus.[5] The nine hydrocephalic patients in this report have all continued to require a functioning shunt.

Conclusions

Our experience indicates that the great majority of spina bifida aperta defects can be satisfactorily repaired within 24 to 48 hours of birth. When this is accomplished before an unepithelialized lesion becomes infected and before the bowel flora develop, the wounds have a much better chance for primary healing, the incidence of meningitis is significantly lower, and worsening of the degree of paraplegia is prevented. Shortly after birth, the mobility of the skin is maximal, good tissue planes are available, and identification and preservation of nervous tissue is relatively easy. Other advantages to this approach are that a severe stigma is removed, ordinary infant care by the parents is made possible, and coexisting skeletal deformities and urinary tract problems can be more easily managed.

Which of these children should not have received vigorous, ongoing treatment must await long-term analysis of the degree of mental and physical function achieved, as well as candid interviews with the patients and their families.

References

1. Lawrence, K. M. and Tew, B. J.: Natural History of Spina Bifida Cystica and Cranium Bifidum Cysticu. Arch. Dis. Child. 46:127-138, 1971.
2. Matson, D. D.: Neurosurgery of Infancy and Childhood, Charles C. Thomas, Springfield, Ill., ed. 2, 1969.
3. Bassett, R. C.: Neurologic Deficit Associated with Lipomas of Cauda Equina, J. Ann. Surg. 131:109-116, 1950.
4. Ames, M. D. and Schut, L.: Results of Treatment of 171 Consecutive Myelomeningoceles, 1963-1968, Pediatrics 50:466-470, 1972.
5. Page, L. K.; Bresnan, M. J., and Lorenzo, A. V.: Cerebrospinal Fluid Perfusion Studies in Childhood Hydrocephalus. Surg. Neurol. 1:317-320, 1973.

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When the world seems large and complex, we need to remember that great world ideals all begin in some home neighborhood.

Konrad Adenauer

A Synopsis of the Neurosurgical Treatment of Pain

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Abstract: The neurosurgeon has a wide variety of procedures available for management of intractable pain. These procedures can be among the most gratifying to the primary care physician, neurosurgeon and the patient. Proper patient selection is the key to a good result and is emphasized here. The most established procedures are listed along with a brief description of their indications, rate of success and complications.

Although the neurosurgical destruction of a portion of the nervous system for treatment of pain may sound quite negative, such procedures can be among the most gratifying to both physician and patient. Each patient with intractable pain presents a unique problem. Very careful patient selection as well as the choice of proper procedure for each individual patient are mandatory prerequisites for a favorable outcome. Even when these criteria are completely adhered to, occasional failures are the rule. Neurosurgical experience with intractable pain has quite rapidly expanded in recent decades. Larger operated patient populations have become available for analysis and follow-up. Numerous technical innovations have not only enlarged the neurosurgeon's armamentarium but at the same time enlarged the numbers of suitable candidates. This increasing experience has brought the neurosurgeon's attention to previously unrecognized problems in pain management. Notably among these is that neurosurgeons have repeatedly found that previously accepted anatomical pathways are not as constant as originally thought. Furthermore, neurosurgeons are finding the central nervous system has the ability to open "alternative" pathways of pain conduction following proper anatomical ablative procedures.

Thus, all of the above supports our previous emphasis on the demand for the most careful patient selection and choice of procedure.

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Patient Selection

Our comments in this section will focus in three areas: first, general considerations of the patient for potential pain surgery; second, the cancer patient, and lastly the patient with benign or long-standing pain.

1. GENERAL CONSIDERATIONS

First, the neurosurgeon should be certain that complete and adequate treatment for the patient's primary disease process has been exhausted. Recent well-founded studies have shown that the phenothiazines or the tricyclic antidepressants or combinations of these may obviate the need of pain surgery when combined with the judicious use of minor analgesics. Conversely, the patient should not be allowed to proceed to narcotic addiction or prolonged bed confinement by his primary care physician or the neurosurgeon to the point where rehabilitation is impossible even with adequate surgical relief of pain.

Next, the neurosurgeon is obligated to know the patient well. He must understand the area, nature and extent of pain to properly choose the type and extent of procedure done. Repeated visits to listen to the patient are mandatory. There is never an urgency to make a surgical decision in these cases.

Finally, both the patient and his family must be repeatedly informed of the underlying potential morbidity of the proposed procedures and must be willing to accept this risk for the relief of pain.

2. THE CANCER PATIENT

In general, the life expectancy of the patient must be long enough to justify the surgical procedure. If greater than three months is expected an "open" surgical procedure can be justified if indicated. For shorter life expectations injections or percutaneous procedures may be justified.

Obviously the neurosurgeon should try to assure that the patient can tolerate the proposed procedure and has no accompanying condition which would be an absolute contraindication. For this the neurosurgeon is obligated to cooperate closely with the patient's primary care physician.

Following a successful pain procedure in cancer patients, even the highest levels of narcotics are usually quickly and easily withdrawn without untoward effects.

3. THE PATIENT WITH THE PAIN OF BENIGN DISEASE OR LONG-STANDING PAIN

These are generally the most difficult patients of all to treat. For example, any "pain" which has been present five or more years is not likely to respond to any ablative procedure. Conversely, most procedures can be expected to have a limited period of effectiveness. The classical example of this problem is the cordotomy which seldom relieves pain for greater than five years and frequently for much less time than this. Such a procedure could rarely be recommended for benign disease and then it would be performed with the idea that repeat procedures would likely be required. Furthermore, it is generally quite difficult to withdraw these patients from their narcotics and other drugs even after a proper surgical procedure.

Ablative procedures for pain do just that: relieve pain. The patient who has a large component emotional "suffering" incorporated into their life pattern will almost invariably be failures or partial failures. Simply stated: with the possible exception of lobotomy, surgical procedures on the nervous system will not relieve the patient who is enjoying secondary gain from their pain.

Thus, the neurosurgeon is compelled to remember that not all "pain" can be relieved by operative intervention and some can even be made worse.

Specific Procedures

Space will allow little more than enumeration of some of the available procedures. However, we have had experience with and are currently using all of the listed procedures in a general neurosurgical practice and so can speak with some personal knowledge on indications and results. Finally, we must emphasize that not all neurosurgeons would agree with portions of the above generalizations nor is there unanimous agreement on the indications and results noted below.

1. ALCOHOL OR PHENOL INJECTIONS

These agents may be used for pain involving peripheral nerves (i.e. intercostal), cranial nerves (i.e. trigeminal neuralgia) or given intrathecally (i.e. rectal pain). Thus, these techniques do have some valuable uses. However, difficulties in control of the extent of neural disruption, and the tendency for the pain to return rather quickly, limit the usefulness of these procedures.

2. PERIPHERAL NEURECTOMY (OR NEUROLYSIS)

Specific peripheral entrapment syndromes (i.e. carpal tunnel syndrome) respond well to neurolysis. However, because of sensory overlap it is difficult to denervate by nerve section any large area without producing unacceptable morbidity.

3. POSTERIOR RHIZOTOMY

This procedure requires laminectomy and consists of the sectioning of the dorsal nerve roots adjacent to the spinal cord. Wide areas can be easily and safely denervated this way but has limited usefulness when the roots supply an extremity. An arm or leg with no sensation whatsoever is just as useless as one which is paralyzed. The procedure does have value for pain involving intercostal nerves, i.e. post-thoractomy incisional pain. A preliminary paravertebral block with Xylocaine will give the patient a preview of the permanent anesthesia and the surgeon partial assurance that the rhizotomy will be effective.

4. CORDOTOMY

This ordinarily refers to destruction of the anterior lateral quadrant of the cord to interrupt the spinothalamic (pain and temperature carrying) path to the brain while sparing proprioception, touch and motor power. This is a well established procedure for pain below the cervical level. Complications include rare paresis or paralysis of the legs and a few percent loss of sphincter control. Unfortunately the procedure has a limited duration of effect, as previously noted. It can be performed percutaneously, stereotatically or as an open procedure.

a. Percutaneous Stereotactic Cordotomy — This procedure is easily accomplished with local anesthesia. The lesion is made using radio frequency

current into an electrode in the cord. This procedure is primarily used when the pain is unilateral.

b. Open Cordotomy — This procedure requires laminectomy and the lesion is made under direct visualization. This is probably the choice method of treatment of midline or bilateral pain problems.

5. SYMPATHECTOMY

a. Cervical — This is primarily used for causalgias of the upper extremities. Although the sympathetic chain can be easily exposed and transected by an anterior approach, the preferred method is posteriorly paraspinal which avoids the Horner's syndrome.

b. Splanchnicectomy — This is usually quite an effective method of pain relief for malignancies of abdominal visceral, especially the upper viscera. It is technically simple with little risk to section the sympathetic chain along with the greater and lesser splanchnic nerves through an extrapleural approach after removal of the medial portion of the eleventh rib.

6. HYPOPHYSECTOMY

Any patient who has disseminated breast or prostatic cancer and who has exhausted the simpler procedures of hormone manipulation, x-ray therapy and chemotherapy is a candidate for this procedure. Good to excellent paliation can be achieved in 60% to 75% of patients — the breast cases generally doing better. Results will improve even further for the breast cases as the estrogen-receptor cancer cell test becomes more readily available. The pituitary can be removed with low mortality and morbidity transcranially, but we feel as do the majority of neurosurgeons now, that the transsphenoidal route is the procedure of choice, with even lower morbidity.

7. ELECTRONIC STIMULATING PROCEDURES

Stimulators may be implanted in the brain, on the spinal cord, on peripheral nerves or on the skin to alleviate pain of various etiologies. The cost and morbidity of implanted stimulators have limited their usefulness, and the newness of external stimulators precludes a decision on the scope of their value.

8. PERCUTANEOUS TRIGEMINAL THERMOCOAGULATION

This is now the procedure of choice for tic douloureax. It is carried out with x-ray control and Brevital anesthesia. It is safe, effective and repeatable if necessary.

Procedures such as medullary and mesencephalic tractotomy for head and neck pain, stereotactic cingulumotomy and thalamotomy for chronic pain have not been discussed for these are procedures usually performed only in centers specializing in difficult pain problems.

Bibliography

Heisey, W. G. and Dohn, D. F.: Splanchnicectomy for Treatment of Intractable Abdominal Pain, Cleveland Clinic Quart. 34, 1967.

Leis, H. P.; McKinnon, W. M., and Bowers, M. F.: Comparative Value of Adrenalectomy and Hypophysectomy in Treatment of Disseminated Mammary Carcinoma, J. Inter. C. S. 40, 1963.

West, C. R. and Murphey, G. P: Pituitary Ablation and Disseminated Prostatic Carcinoma, JAMA 225, 1973.

White, J. C. and Sweet, W. H.: Pain and the Neurosurgeon, Charles C. Thomas, Springfield, Ill., 1969.

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It is easier to be wise for others than for ourselves.—La Rochefoucauld

Selective Percutaneous Radiofrequency Coagulation of Gasserian Ganglion for Trigeminal Neuralgia

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Abstract: The surgical treatment of choice in trigeminal neuralgia is a percutaneous selective radiofrequency lesion of the Gasserian ganglion. The procedure and its complications are reviewed. The term "percutaneous" means that the treatment is done with a needle passed through the skin. The term "sterotaxic" refers to the fact that the needle is directed by x-ray control, and "radiofrequency" refers to the radiofrequency heating current which is used to destroy the nerve. This procedure carries less risk than previous open operations on the trigeminal nerve but has approximately the same success rate.

The treatment of trigeminal neuralgia has changed rapidly within the past few years. The majority of patients are now well controlled with medical treatment. The neurosurgeon is called when the patient cannot tolerate or does not respond to either Tegretol or Dilantin. The surgical treatment of choice is now percutaneous selective radiofrequency coagulation of the Gasserian ganglion. This procedure can be carried out in all age groups and is particularly advantageous in the elderly, the group that is most prone to develop trigeminal neuralgia. The success rate is high, the recurrence rate low and the risks and complications are minimal.

The Procedure

The patient is positioned on the x-ray table where both polaroid and AP fluoroscopy are available. The trigeminal needle is introduced through the cheek on the painful side lateral to the corner of the mouth and directed to the base of the skull to the projected site of the foramen ovale. Using x-ray control the needle is guided through the foramen ovale, and AP and lateral skull x-rays are obtained to check the intracranial position of the needle (Fig. 1). The divisions of the Gasserian ganglion which are encountered sequentially after passage of the needle through the foramen ovale are the mandibular, maxillary, and ophthalmic in that order (Fig. 2).



Fig. 1.—Lateral skull x-ray showing electrode needle in Gasserian ganglion. Coagulation at this particular site produced analgesia of the maxillary division selectively.

From the Department of Neurosurgery, St. Vincent's Medical Center, Jacksonville.



Fig. 2.—Cadaver specimen of skull base with basal dura removed showing the Gasserian ganglion with its three divisions. The electrode needle tip (arrow) is shown where it would be in an actual coagulation of the retrogasserian fibers.

Using a small stimulating current, with the patient awake, one can readily ascertain where the electrode lies within the Gasserian ganglion from the patient's responses. Stimulation will produce tingling or pain into the area of the face supplied by the division of the trigeminal nerve being stimulated. Stimulation will often reproduce the tic pain. When the electrode needle is located in the desired portion of the Gasserian ganglion, the patient is anesthestized briefly using intravenous Brevital. With the patient asleep a radiofrequency heat lesion is made at 80 degrees centigrade for 30 seconds. The patient is allowed to awaken and the resultant area of analgesia is tested. It is important that the resultant analgesic zone includes the trigger point for the pain.

This procedure has now become well established as the surgical procedure of choice in trigeminal neuralgia. It can be readily carried out in elderly patients who are in poor health. The resultant analgesia can be limited to the division of the trigeminal nerve involved by the tic. The procedure can be done in less than an hour. The patient's average hospital stay is only two days. The recurrence rate of the trigeminal neuralgia is between 10% and 20%[1,2] which is comparable to that obtained with more hazardous operations on the retrogasserian fibers in the middle fossa or Dandy's operation on the trigeminal nerve in the posterior fossa.

The complication rate is approximately 3%. Complications include: (1) Inadvertent puncture of the carotid artery in foramen lacerum. Careful x-ray monitoring helps avoid this. (2) Coagulation of the motor root of the trigeminal nerve with masseter and peterygoid weakness. This complication often subsides within six months to a year. (3) Transient abducens nerve palsy. (4) Corneal anesthesia causing delayed corneal ulcers. The latter is a complication of coagulation of the ophthalmic division and the tendency toward corneal ulceration can be minimized by careful use of eye drops and avoiding foreign bodies in the eye. (5) Anesthesia dolorosa. This complication occurs infrequently in radiofrequency coagulation of the Gasserian ganglion because ordinarily touch may be preserved in the analgesic zone.

In conclusion, percutaneous selective radiofrequency coagulation of the Gasserian ganglion is the surgical procedure of choice in the patient with trigeminal neuralgia who does not respond to Dilantin or Tegretol. The risks of the procedure are minimal and it can be done in the elderly or ill patient who otherwise could not tolerate a major surgical procedure. The avoidance of complication may be reduced by strict attention to needle position as monitored by x-ray and by the electrical stimulation. This operator has been extremely satisfied with the results.

References

1. Onofrio, B. M.: Radiofrequency Percutaneous Gasserian Ganglion Lesions, J. Neurosurg. 42:132-139, 1975.
2. Nugent, G. R. and Berry, B.: Trigeminal Neuralgia Treated by Differential Percutaneous Radiofrequency Coagulation of Gasserian Ganglion, J. Neurosurg. 40:517-523, 1974.

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Stereotactic Percutaneous Cordotomy

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Abstract: The technique and neuroanatomic rationale of percutaneous cervical cordotomy are reviewed. Using local anesthesia with the patient awake, a stereotactic lesion is placed in the anterolateral quadrant of the spinal cord, destroying the lateral spinothalamic tract. The procedure provides patients with cancer relief from pain. The best candidates are those whose pain is unilateral. The principal risk is ipsilateral weakness. Touch sensation is preserved.

Stereotactic percutaneous cordotomy has been in use for approximately 12 years. Precise, accurate lesions can be placed in the spinal cord with reliable results and few complications. Prior to its development open surgical cordotomy, through a laminectomy, was required. The percutaneous technique has now largely supplanted this open surgical procedure.[1, 2]

Rationale

Pain fibers enter the spinal cord in the dorsal root, cross the midline, and ascend in the lateral spinothalamic tract in the anterolateral quadrant of the opposite side (Fig. 1). Some ascend or descend several segments in the spinal cord before crossing to the lateral spinothalamic tract. This pain pathway terminates in the thalamus.

Thus, the pain fibers from a particular part of the body are found in the opposite anterior quadrant of the cord. They are organized anatomically with the cervical fibers more anteromedial and lumbar and sacral segments more posterolateral. Destruction of the fibers in this tract has long been known to cause contralateral analgesia. At open cordotomy the anterior quadrant of the cord is divided by a knife blade. At percutaneous cordotomy a needle is introduced through the skin and into the spinal cord and a similarly located, but more precise lesion, is made by heat from a radiofrequency current. The area of destruction is shown in Figure 1.

Technique

The procedure is done with the patient awake. A C-Arm fluoroscopy unit or portable x-ray equipment is required. Local anesthetic is infiltrated in the neck on the side opposite the pain. The midpoint of the C1-2 interlaminar space is selected for puncture of the subarachnoid space. A #18 spinal needle is inserted through the interspace, puncturing the dura. When spinal fluid is obtained, 1 cc of Pantopaque is instilled to outline the dentate ligament. An electrode is inserted through the needle and advanced into the spinal cord. The goal is to insert the electrode just anterior to the dentate ligament. Its penetration of the spinal cord can be detected by feel or by instrumentation which measures the impedence change from spinal fluid to the cord. The spinal cord is than electrically stimulated to determine the precise location of the electrode. If the correct target, that is the spinothalamic tract in the anterior quadrant of the cord, is penetrated, stimulation will produce paresthesias or a burning pain on the opposite side of the body. If such a

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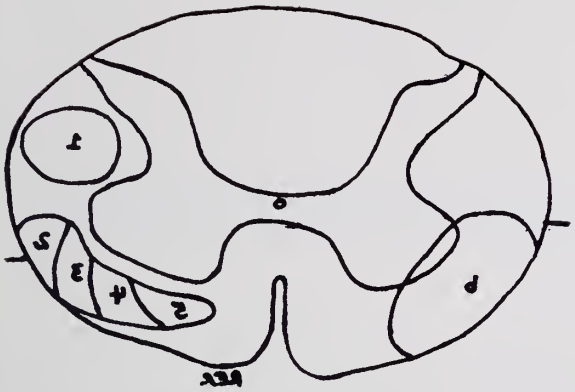


Fig. 1.—(1) Lateral corticospinal tract, (2) Sacral segments of lateral spinothalamic tract, (3) Lumbar segments of lateral spinothalamic tract, (4) Thoracic segments of lateral spinothalamic tract, (5) Cervical segments of lateral spinothalamic tract, and (6) Approximate area of lesion in spinothalamic tract.

sensory response is not obtained, the needle is withdrawn slightly and reinserted, more anteriorly or posteriorly in the cord as may seem appropriate from the stimulatory response, searching for the lateral spinothalamic tract.

Selection of Patients

Cordotomies, both open and percutaneous, have long been known to give immediate and complete pain relief; however, frequently the pain returns in several years. Thus, it is rare for a cordotomy to be done for pain due to benign condition. Its main use has been in treatment of patients with a limited life expectancy because of malignant disease. The best candidates are patients with malignant tumors causing pain in one upper or lower extremity or one side of the chest. Examples are pain due to carcinoma of the cervix involving the lumbosacral plexus or metastatic mammary carcinoma in the brachial plexus. The cordotomy may be done unilaterally or bilaterally. However, with bilateral lesions, there is a risk of respiratory paralysis. This sometimes manifests itself as an absolute respiratory depression, and other times as a failure of autonomic respirations during sleep. This occurs because the pathways for respiration are just anterior to the spinothalamic tract in the anterior quadrant which is being destroyed. Staging each side of a bilateral procedure a few weeks apart reduces the incidence of this complication. Loss of bladder control occurs in approximately 15% of the patients who have bilateral lesions.

Ipsilateral weakness can result because the spinothalamic tract is adjacent to the lateral corticospinal tract which carries the motor fibers. A lesion in the anterior quadrant extending slightly posterior to the dentate ligament may produce some weakness in the ipsilateral arm or leg. Stimulation prior to lesion making helps avoid the corticospinal tract and such weakness because the electrode is moved if stimulation gives a motor response.

The major advantage of this technique over the open technique is the ease with which it can be performed and the precision with which a lesion is made. Pain relief can be given to very debilitated patients who would not be able to tolerate major open surgery.

References

1. Hekmatpanah, J.: Techniques and Results of Percutaneous Cordotomy; Med. Clin. N. A. 52:189-201, 1968.
2. Rosomoff, H. L.; Carroll, F.; Brown, J., and Sheptak, P.: Percutaneous Radiofrequency Cervical Cordotomy: Technique, J. Neurosurg. 23:639-644, 1955.

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The first thing to do in life is to do with purpose what one proposes to do.

Pablo Casals

Electrical Modulation of Nervous System Function

Invited Comments

Charles Burton, M.D.

Even in the age of space technology where electronic sophistication has become commonplace, we still stand in awe of the profound complexity of the human nervous system. It is now, and is likely to remain, the most difficult frontier for the medical pioneer. Although the great majority of nervous system function remains to be defined, means are now developing by which its function can be modified in desirable directions by the application of electrical stimulation. The papers in this issue of the Journal of the Florida Medical Association by neurosurgeons Donald Dooley, Ross Davis and their associates are of great interest in that they represent pioneering efforts in the application of implanted electronic devices to modify (modulate) function of the nervous system in order to treat difficult clinical problems.

The initial implanted electronic neurostimulator was designed by Dr. C. Norman Shealy in 1967 as a means of controlling severe pain. Since that time the most common use of implanted electronic devices has been for pain relief. The application of Dr. Shealy's "dorsal column stimulator" required major surgery on the spine. Dr. Dooley's work in the development of a simplified percutaneous implanted neurostimulator system represents a more practical approach, particularly for debilitated patients such as those with multiple sclerosis.

Dr. Davis' application of implanted cerebellar neurostimulators to relieve spasticity in cerebral palsy creates hope for many patients whose damaged nervous system has prevented them from effective use of their motor abilities. Because of the work by these neurosurgeons, the present discouraging status quo in the treatment of multiple sclerosis, cerebral palsy and other similar afflictions may be significantly altered.

The greatest apparent advantage of implanted electronic devices for relief of spasticity as described here or for many other medical problems now being studied lies in the basically nondestructive nature of the mode of therapy which is a physiological "augmentation" of function. At the same time, the greatest liability exists in the area of over-expectation on the part of patients whose situations were previously considered "hopeless" by the medical profession. It is important to realize that the use of implanted electrical neurostimulators is in its infancy. Instrumentation will require greater sophistication to solve existing technical problems and much work remains to be done to define indications for use. Those physicians who choose to meet these challenges face a difficult task associated with formidable responsibility. In addition to the common complications of surgery, they must also bear the common complications and failures of sophisticated electronic devices.

Despite these shortcomings, it appears likely that during the next decade, implanted electronic devices, designed to modulate function of the nervous system, will play a very significant role in the control of pain, treatment of epilepsy, motion disorders, spasticity, as well as muscle control, control of powered prostheses, visual and auditory prostheses and also play a significant role in wound and bone healing. The body, as a biochemically mediated electrical phenomenon, is potentially influenced in many ways. The productive modulation of its function by electricity is limited only by imagination.

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Peripheral Nerve Stimulation for Pain Control

Jorge A. Picaza, M.D.

Abstract: This is a review of the current status of attempts to control pain by peripheral nerve electrical stimulation. The fundamental basis and general methodology for clinical application are given. The conditions for which this form of therapy is most effective are described.

The observation that pain could in some way be modified or stopped by electrical stimulation of the skin, or nerve, is a part of ancient medical history. For about a decade, motivated by electronic developments, a renaissance of such a practice has occurred, this time supported by the "gate theory" that stimulation of large sensory fibers conveying touch inhibits impulses from small pain fibers. A group of clinical investigations, based primarily on the "gate theory" proposed by Melzack,[1] approached the problem by attempting direct stimulation of the spinal cord, but the procedure (dorsal column implantation) has largely been abandoned because the morbidity related to the surgical procedure was significant. However, electrical stimulation by less invasive techniques through the intact skin (transcutaneous nerve stimulation, or T.N.S.), has proven to be a simple and effective tool in dealing with certain specific pain problems.

Methods

Inputs can be provided to the peripheral nervous system by stimulating the nerve end organ receptor of superficial or deep sensibility. This is achieved by applying one large electrode or many small electrodes over the painful area. A simpler and usually more efficient modality consists of bypassing the nerve end organ and applying the electrodes to the skin immediately on top of one or several of the nerve trunks subserving the area of pain. By placing the electrodes close together, a localized electrical field is obtained which, when located on top of a mixed nerve trunk, depolarizes a very large number (if not all) of nerve fibers. Some degree of fiber size selection can be achieved by controlling the wave width of the stimulating signal. The larger the wave width (0.3 to 0.5 msec), the larger the myelinated fiber stimulated, and the smaller the width (0.1 to 0.2 msec), the smaller the fiber stimulated. The intensity of the current is kept at sensory-motor threshold throughout. Regardless of the electrode placement selected, the parameters (rate and intensity) that appear to offer maximum benefit appear to be case-specific; therefore, there is the need to try different settings (optimization). Any setting should be tried on a continuous train of stimulation of 30 to 45 minutes before it can be established that the necessary time to induce the phenomenon of pain suppression has elapsed. Once it is clear to the patient that certain parameters are effective, and the duration of the after effect has been noted, the physician may elect either intermittent application on different days or the continuous administration of stimuli for many days by using a portable unit.

The previously described methods are transcutaneous (T.N.S.) and not invasive. Only in such cases where continuous stimulation for a long period of time (months) is expected might one consider that efficiency and convenience may be gained by implantation of the device (Fig. 1). In my experience, this is not more than 3% to 5% of cases.

Results

Initially attractive was the possibility of inducing the phenomenon of pain suppression by stimulating peripheral nerves, thereby avoiding invasive procedures to the spinal cord. A systematic and strictly controlled study was made of 100 patients affected with pain of different origins.[2] All were treated systematically the same and were evaluated with similar criteria as adopted from the pharmacologists'

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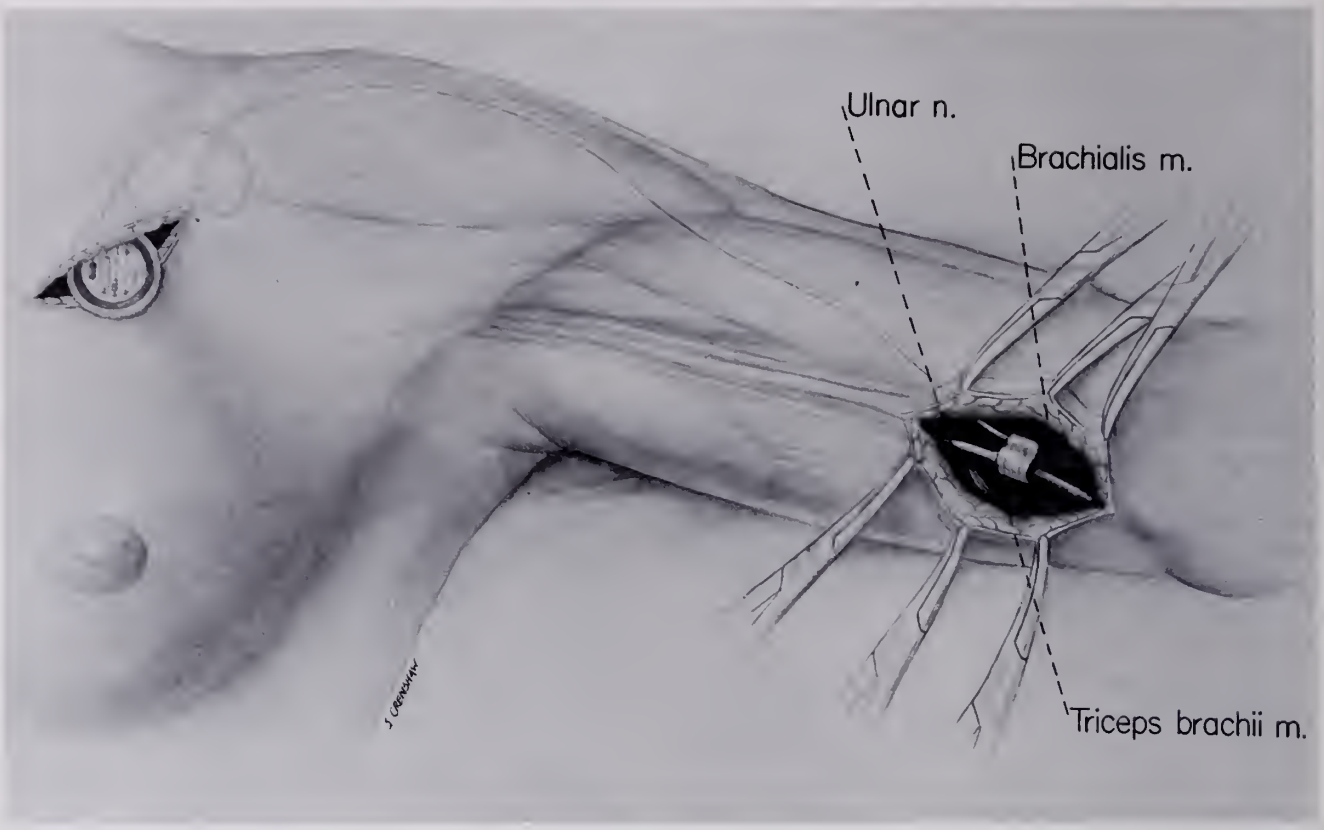


Fig. 1.—Implanted nerve stimulator. Note the wrap-around electrode in the nerve connected subcutaneously by a wire to a minute radio receiver. This system is activated through the skin by means of a superimposed antenna. The controls are the same as in transcutaneous nerve stimulation.

study on analgesics. The only variables were the frequency (between 1 and 250 Hz) and the intensity of stimulation. The results of this study were later corroborated by observations of 400 further cases (Fig. 2) in which more than one half the patients reported what they estimated was significant relief. This relief as described showed some special characteristics: it appeared after some period of continuous stimulation (minutes or hours); it exceeded the period of stimulation (after-effect), and it could be obtained by stimulating nerves within the area of pain reference but also occasionally from stimulation of distant nerves. The phenomenon of pain disappearance under the effects of electrical inputs could be reproduced indefinitely on the susceptible person and was designated "pain suppression" by Sweet et al.[3]

Unfortunately, it was found that "pain suppression" was not a universal phenomenon and commonly could be obtained only on certain types of patients who showed gross evidence of nervous system damage. Moreover, a small number of patients would show worsening of pain. Despite the limitations, however, the fact that a number of patients

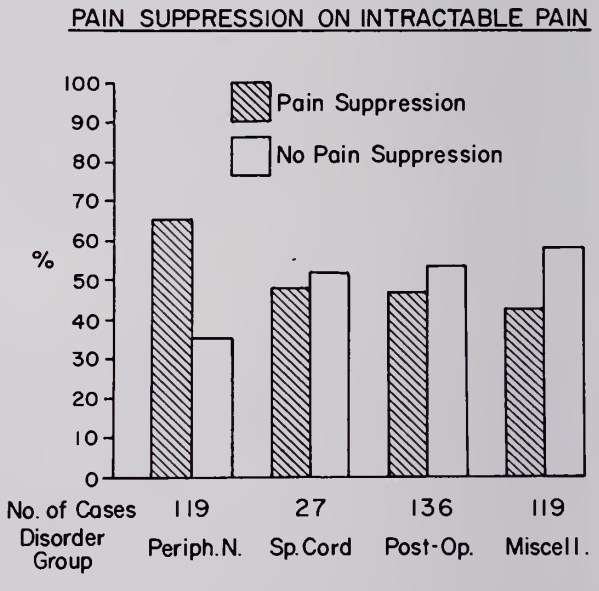


Fig. 2.—Results of the testing for pain suppression in 400 cases of intractable pain of different origins. Note that the group of disorders related to peripheral nerve disease is the only one showing clearly significant benefit from the procedure.

could be benefited reopened the possibility of using this phenomenon as a way to alleviate human suffering (Fig. 3).

Clinical Applications

It appeared increasingly evident from first observations that presence of the phenomenon of pain suppression on a patient was not related to sex, age, personality, body area of pain, or kind of nerve stimulated, but to the pattern of pain. It suppressed pain of an ill-defined quality that increased with activity but had no mechanical character; that overflowed dermatomal organization; was described as "boring," throbbing, aching or fully disesthetic or paresthetic (burning, cold, crawling, tightening, drawing, etc.); was at times fully causalgic. It was frequently associated with local tenderness and a strong emotional component detectable on the Minnesota Multiphasic Personality Inventory. Note that these descriptions resemble the concepts of "protopathic" and "central pain," and cover the patients affected with the so-called "neuralgias" known for their notorious resistance to all forms of treatment.

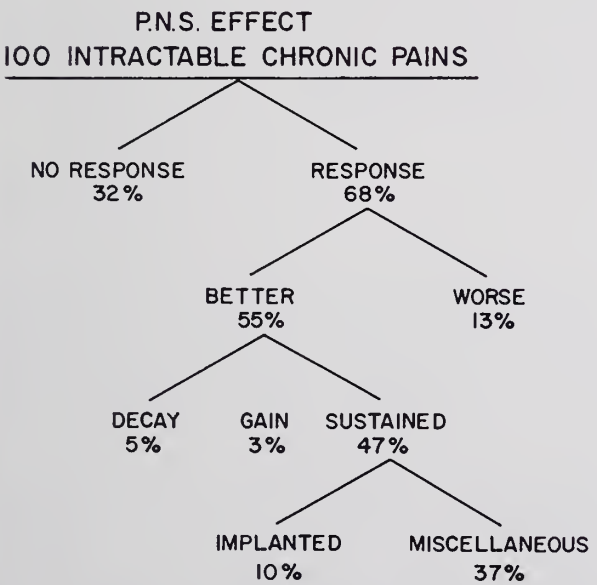


Fig. 3.—Responses obtained on a number of cases of chronic pain of different sources under the effect of peripheral nerve stimulation. Only a few eventually gained therapeutic benefit from the procedure.

Of all patients observed and treated in this clinical program, it became evident that in some the treatment itself was capable of affording relief, and in others concomitant drug therapy or complementary therapeutic measures were required. For example, peripheral nerve disorders may be significantly alleviated in as many as 75% of cases. However, mononeuritis (entrapment) as well as polyneuritis could be symtomatically helped, although in the former the mechanical release of the entrapment might be eventually necessary. Facial pain of the tic douloureux type could seldom be fully suppressed without the concomitant use of analgesic drugs. Atypical facial pain and particularly the dreaded analgesia dolorosa were among the observed syndromes that obtained considerable relief. Painful postamputation symdromes could also be controlled, particularly phantom pain in which pain disappeared initially although the "phantom" persisted and gradually faded away. The so-called stump neuralgias, however, were not shown to be amenable to the procedure.

Perhaps the most dramatic of these disorders relieved was pain due to direct peripheral nerve injuries, or soft tissue injuries, of which almost every case observed was able to obtain relief to some degree. Zosterneuritis deserves special mention here. Many of the patients affected with this near incurable disorder received considerable palliative relief. They required, however, special techniques of treatment and extensive trials before the optimal benefit could be achieved.

Postoperative neuralgias are among the others that could also be alleviated to some degree. Unfortunately less than 50% of cases in the complex group of postlumbar disc residual neuralgias achieved relief. This approaches the placebo level. Spinal cord disorders (syringomyelia, traumatic myelopathy, angioma, M.S., postcordotomy pains.) were found amenable to treatment in about 50% of cases. In the remaining disorders where the procedure was tried the benefit accrued was very close to the level of 35% to 40% of cases — or placebo incidence. This included (among others): cancer, spinal sprain, arthropathy, scoliosis, and spondylosis.

References

1. Melzack, R. and Wall, P.: Main Mechanism: New Theory, Science 150:971-979, 1965.
2. Pain Symposium. Surgical Neurology, Vol. 4, 1975.
3. Sweet, W. H. and Wespic, J. G.: Stimulation of Pain Suppressor Mechanisms; Critique of Some Current Methods, Adv. in Neurology 4:734-747, 1974.

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Electrical Stimulation of the Spinal Cord in Patients With Demyelinating and Degenerative Diseases of the Central Nervous System

Donald M. Dooley, M.D., Mary Kasprak, R.N. and Marie Stibitz, R.N.

Abstract: Electrical stimulation was applied to the spinal cords of 47 patients with demyelinating and degenerative diseases of the central nervous system and to one patient with a spinal cord injury. Forty-two patients had multiple sclerosis, two olivo pontocerebellar atrophy, one amyotrophic lateral sclerosis, one primary lateral sclerosis and one Friedreich's ataxia.

Twenty-one of the patients with multiple sclerosis had significant lessening of dysfunction of various sensory modalities, voluntary and involuntary motor systems, brain stem and neurogenic bladder. The patient with amyotrophic lateral sclerosis had no improvement. One of the patients with olivopontocerebellar atrophy had lessening of ataxia. The patient with primary lateral sclerosis had lessening of spasticity and increase in voluntary motor function of his extremities. The patient with Friedreich's ataxia had increase in voluntary function of extremities, lessening of ataxia and improvement in posterior column sensation. Three of the patients with multiple sclerosis became worse and two of these regained their lost neurological function.

The electrical stimulation is applied to the spinal cord by a percutaneous technique which is performed under local anesthesia.

Electrical stimulation has been applied to various portions of the nervous system for many years in attempts to induce contraction of muscle and to alleviate pain.[1,2]

In 1973 Cook and Weinstein reported an instance of electrical stimulation of the spinal cord in an effort to relieve some of the intractable pain in the back of a patient who had multiple sclerosis.[3] This goal was accomplished and progressive improvement in ataxia, voluntary motion of extremities and brain stem and sensory function were observed with 21 months of stimulation. Four more patients who had multiple sclerosis but not intractable pain had similar operations performed with similar results. These patients had the electrical impulse conveyed to the spinal cord by operative implantation of a Dorsal Column Stimulator into the subdural space. Since that time the percutaneous technique, which is performed under local anesthesia, has replaced the operative method which required general anesthesia and laminectomy.[4] The percutaneous method also has the advantage that it can be used as a temporary testing procedure

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which can be converted into a chronic permanent therapeutic system. In the testing procedure the electrodes are placed in the spinal epidural space in the cervical or thoracic regions and connected to a Percutaneous Electrical Stimulator. The electrodes are kept under a sterile dressing and the stimulation applied for three to seven days. If significant improvement is noted in some of the signs and symtoms then the electrodes are connected to a receiver and all these elements placed under the skin. The current is transported from the Transmitter to the spinal cord by an antenna which is connected to the Transmitter and placed on the skin over the receiver.

Selection of Patients

From January 1975 through December 1975, 48 patients with diseases of the central nervous system not amenable to surgical treatment were selected for electrical stimulation of the spinal cord in an effort to favorably alter motor and sensory dysfunction.

The first patients seen for evaluation were those who had multiple sclerosis. Later in the year patients with amyotrophic lateral sclerosis, primary lateral sclerosis, Friedreich's ataxia, olivopontocerebellar degeneration and spinal cord injury were also examined and evaluated.

The first problem in evaluating the patients was establishing the correct diagnosis. The medical records were reviewed. All patients had been seen by at least two medical neurologists or neurosurgeons who had agreed on the diagnosis. Appropriate diagnostic methods had been employed and the diagnosis made to the satisfaction of the patient and physician.

It was thought that the disease process should have been stable for at least six months prior to stimulation in order to be able to evaluate the effects of the stimulation. This was not possible in two of the patients. The patients were maintained on the same dosages of muscle relaxants and steroids. During the phase of evaluation during stimulation the patients were not given physical therapy even if they had been on a regular program prior to stimulation.

Patients who were paraplegic or quadriplegic were not stimulated in the hope of altering the voluntary motion of the plegic extremities. One patient who was quadriplegic had stimulation of the upper thoracic spinal cord. He was a physician and the procedure was not performed on a lay person with similar disability.

Those patients who were thought to have poor motivation to follow up with physical therapy and to keep the stimulator functioning were not admitted to the hospital for temporary testing.

The attitude of the family of persons afflicted with chronic debilitating diseases is most important for the care of the ill member of the family. Many of these patients had been abandoned by different members of their families. However, as long as at least one person seemed interested in them they were not denied stimulation on the basis of post-operative care by their families. Unfortunately, judgment in this regard was not always correct.

Patients and/or families of patients who could not understand the procedure or how to operate the machinery were rejected.

Patients with serious illness of other organ systems such as metastatic malignancy, uncontrollable systemic hypertension or vascular disease were rejected on those grounds.

Monitoring of Patients

Routine neurological examination with careful recording of findings was performed. Upon admission to the hospital the patient was examined by members of the Department of Physical Medicine and Rehabilitation and video-tape movies were taken to record gait and motor abilities. Many, but not all, of the patients had evaluation of urinary bladder function by the use of cystometrograms, intravenous pyelograms and measurements of residual urines. All of these findings were then reevaluated during stimulation.

Resume of Results

Improvement in at least one sign and symptom was documented in 30 out of the 48 patients who had electrical stimulation applied to the spinal cord. This is not to say that the patient was alleviated of all of that one symptom or that the improvement resulted in rehabilitation of that individual patient.

Better control of urination, lessening of spasticity, increased voluntary control of extremities, and lessening of dysarthria, dyspnea and sensory abnormalities were recorded in various patients. Detailed descriptions of each patient in regard to lessening of neurological dysfunction is not possible in this brief publication.

Five patients had diminution of ataxia of the upper extremities so that they were able to perform such tasks as feeding themselves, picking up and holding objects, buttoning clothes and turning the dials of the Transmitter which they had been unable

to do without the stimulation. The improvement has persisted in all patients to date except for one patient who died of myocardial infarction.

Seventeen patients had increase in voluntary motor function of one or more extremities which enabled them to walk with less support and over longer distances, to be less confined to their homes and to write more legibly and to better care for their personal needs. This improvement did not persist in three patients. This reversion to prestimulation levels was evident within one week of instillation of a permanent stimulating system in two of the patients. This leads one to seriously question the accuracy of the evaluation. The third patient had regression of the improvement to the prestimulation level four months after permanent implant. The improvement in his ataxia and abnormal involuntary movement disorder persisted.

One patient noted lessening of spasticity of his lower extremities with stimulation but this was persistent for only one month and he has remained at his prestimulation level of dysfunction through the follow-up period.

One patient observed intermittent stimulation with movement of her neck four months after the permanent stimulating system was installed. There was regression of her paraparesis to the prestimulation level over a four week period. The relief of urinary symptoms and intractable pain in her lower extremities has continued.

Significant lessening of urinary frequency and incontinence by at least 50% was noticed by nine patients. The residual urines in six of these patients dropped to 50cc or less. In one patient, for example, the residual urine went from 350cc to 50cc. These changes have persisted to date except in one patient. This person now takes diuretics for pedal edema and feels the stimulation only in his right lower extremity. These factors make judgment of the effectiveness of the stimulation most difficult. This patient is not included in the improved group.

Three patients became worse in regards to voluntary motor function in one or more extremities during placement of the electrodes. The electrodes had to be repositioned in all these patients and the worsening occurred during the repositioning procedure. Two of these patients regained the lost function whereas one patient did not do so.

One patient had worsening of her appendicular ataxia during insertion of the electrodes but her dysarthria continues to be improved over prestimulation levels when she uses the stimulator.

One patient became worse in regards to her spastic paraparesis one month after the permanent stimulating system had been installed. She had not had any improvement in neurological dysfunction but had had impressive diminution of intractable pain in her lower extremities for which she had requested permanent stimulation.

Four patients were able to feel the tuning fork in their lower extremities and had not been able to do so without stimulation. Five patients who were unable to distinguish sharp from dull in extremities and trunk were able to do so with stimulation. One patient had a positive Romberg without stimulation and a negative one with stimulation. One patient had improvement in proprioception of her upper extremities when electrical stimulation was applied to her spinal cord.

One patient in this series had a spinal cord injury. Because of extensive multiple operations in the cervical and thoracic regions it was not possible to place the electrodes in these areas. The electrodes were placed in the spinal canal at T 11. There was no effect on motor or bladder function but he was able to distinguish sharp from dull from about the T 11 dermatomic zone downward which he was not able to do without stimulation. There was also a favorable change in posterior column sensation.

Discussion

Thirty out of 48 patients with demyelinating and degenerative diseases of the central nervous system showed improvement in neurological function during electrical stimulation of the spinal cord. Six out of the 30 patients had regression of some signs and symptoms back to prestimulation level. Three of the six patients did not receive adequate stimulation either because of inadequate functioning of the system or because they did keep the stimulation turned on as directed.

The diminution of neurological abnormalities does not necessarily mean that the individual person is rehabilitated or that the progress of the disease will not continue. Whether chronic electrical stimulation of the central nervous system will diminish the progression of the diseases treated thus far is unknown at the present time. A one year follow-up is a short time for diseases which are noted for chronicity.

However, it is interesting to note that one observes a positive correlation between the presence of electrical stimulation and improvement in neurological function in seven patients. These patients

had diminution or absence of stimulation for technical reasons. Their symptoms and objective neurological abnormalities were less with stimulation and more severe without stimulation.

It is theorized that the electrical stimulation alters neurological function by causing chemical changes within the nervous system.

The goal of electrical stimulation of the nervous system is the same as that of any other treatment for those persons severely afflicted with disabling diseases — to make their lifestyles more pleasant and comfortable for themselves and their families.

Summary

Forty-eight patients with demyelinating and degenerative diseases and one patient with a spinal cord injury had electrical stimulation applied to their spinal cords. Of these, 30 had significant improvement in neurological abnormalities such as ataxia, dysarthria, voluntary motor deficit, sensory dysfunction and neurogenic bladder. Six of the patients who improved had regression of some symptoms and signs back to prestimulation level. Three of these six did not receive adequate stimulation.

The less severe the neurological dysfunction the more likely was the patient to show improvement.

No patients with eye movement disorders, loss of visual acuity or sexual potency showed any lessening of these abnormalities.

The long-term effect of electrical stimulation on the course of the diseases treated thus far is unknown at the present time.

References

1. Liberson, W. T.; Holmquest, H. J.; Scot, D., and Dow, M.: Functional Electrotherapy: Stimulation of the Peroneal Nerve Synchronized With the Swing Phase of the Gait of Hemi-Plegic Patients, Arch. Phys. Med. 42:101, 1961.
2. Shealy, C. N.; Mortimer, J. T., and Hagfors, N. R.: Dorsal Column Electroanalgesia, J. Nerosurg. 32:650, 1970.
3. Cook, A. W. and Weinstein, Stanley: Chronic Dorsal Column Stimulation in Multiple Sclerosis, New York J. Med. Vol. 73, No. 24, (Dec. 15) 1973.
4. Dooley, D. M.: Percutaneous Epidural Electrical Stimulation of the Spinal Cord, Asso. Neurol. Surg. Bal Harbour, Florida, April, 1975.

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Cerebeller Stimulation for Cerebral Palsy

Ross Davis, M.D., Robert F. Cullen, M.D., Danilo Duenas, M.D.
and Howard Engel, M.D.

Abstract: A series of 75 patients with cerebral palsy have been implanted with a cerebellar stimulator since February 1974. Sixty-eight of these patients had cerebral palsy at birth; seven patients acquired it through respiratory arrest and brain damage due to trauma and cerebrovascular accidents. Stimulation of the anterior lobe of the cerebellum produced a relaxation of the spasticity. Motor abilities improved as a result of the lessening of muscle tension. The more intelligent, less spastic children achieved considerable progress toward normal. Immature, mentally retarded and very spastic children were more relaxed and better able to be cared for by their parents. All patients still use their equipment and are benefited. No major complications, including infection, have occurred following surgery. The usual hospital stay is eight to ten days.

The major problem in patients with cerebral palsy is the spasticity or increase in muscle tone. The majority of patients have the ability to carry out good motor movements but are greatly encumbered by the increase in muscle tension when wanting to carry out a motor act. Some patients are in constant spasticity and others display the involuntary athetoid movements.

Cerebral palsy generally follows anoxia associated with the birth process. There are all degrees of mental ability from the very brightest children to the immature. However, they are delayed in reaching their milestones because of an increase in spasticity usually recognized toward the end of the first year and leveling off by the age of four or five. Another group of patients are those who have acquired cerebral palsy following brain damage due to automobile accidents, carbon monoxide poisoning, respiratory arrests and even those patients with minimal strokes who have considerable degrees of spasticity.

The cerebellar stimulator was first implanted by Dr. Irving S. Cooper of New York in late 1972 on a patient who had epilepsy.[1] In subsequent cases he used this system on patients with cerebral palsy and found that the spasticity or increased muscle tension was reduced enough for these patients to carry out their motor activity better.[2] Our series over the past two and a half years has encompassed 75 patients with cerebral palsy.[3] These patients have ranged from the age of seven through 53, and include three patients with cerebrovascular accidents, one with carbon monoxide poisoning, one patient who suffered a respiratory arrest during anesthesia and two patients who had serious automobile accidents with brain injury. The major group

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Fig. 1.—(A) A 20-year-old girl with severe spine and head retraction (July 1974). (B) Six months following implantation of stimulator on anterior surface of cerebellum. (C) One year later following implant. (D) February 1976.

of 68 patients suffered their anoxia either prior to, during, or after birth.

The electronic implant is composed of platinum buttons which are placed on the anterior surface of the cerebellum bilaterally. The leads emerge through small craniectomy openings near the occipital protuberance and are placed subcutaneously down the neck to a radio receiver implant. The receiver is a small disc the size of a wrist watch, placed below the clavicle in a subcutaneous pocket on the anterior chest wall. The power to stimulate the cerebellum is supplied to the implanted system by an antenna from a radio transmitter. The transmitter box, the size of a small packet of cigarettes, is powered by a nine volt battery. Electronically generated radio frequency pulses are sent via the antenna which is applied on the skin over the radio receiver. With stimulation, no electricity is felt; however, patients describe their muscles as feeling relaxed.

The cerebellar stimulator, when chronically used, results in a reduction of spasticity or muscle tension. As a result the patient who has ability to move his hands or his legs or speak can do so better; some are markedly improved. However, there are patients who have little motor ability and as a result experience only the benefit of a reduction in muscle tone. Patients who are mentally alert, intelligent, and have minimal spasticity usually are significantly improved. Those patients who are very immature, mentally retarded, have little motor ability, and are difficult nursing problems for the family become easier to manage because the severe spasticity is less. Parents report that children in this severely affected group are more relaxed, able to dress easier and have improved bowel function. This has all led to happier homes when, prior to the implant, they were faced with very rigid children unable to have bowel motions except with enemas and almost totally unable to do anything for themselves. Obviously, there is a continuous gradation from the very worse type of spastic patients to those who are very intelligent and have considerable ability. Within the first week of having the stimulator activated, children become relaxed; their drooling ceases; speech is distinctly improved where children have speech; their hands are able to be used easier and many have been able to open their hands for the first time and pick up objects; scissoring is markedly reduced in the lower extremities; hip flexion and angle movements are sometimes seen for the first time. These improvements continue for many months plateauing in six to 12 months. This does not mean that improvement does not continue, however the rapidity is lessened. Some of the patients have found that after six to 12 months they can go several days without the stimulator being on; the new patterns of movement that they have learned and are doing for the first time still continue even though the stimulator is off.

Of the cerebral palsy group, there have been no major complications, including infection, and all of their stimulators are still working. Patients are given antibiotics during and one week after surgery. The hospital stay is eight to ten days.

Figure 1 shows a patient 20 years of age in whom severe neck retraction developed which had become so intense that she could not lie comfortably or eat solid foods. L-dopa treatment yielded transient success. However, by July 1974 she had reached a severe state of disability and as a result a cerebellar stimulator was implanted (Fig. 1A). Within weeks she was able to lie comfortably and eat better. Gradually, over months, she was able to straighten her neck (Fig. 1B). After one year, improvement was maintained by stimulating only at night (Fig. 1C). Recently, even less stimulation has been required (Fig. 1D, February 1976).

Cerebellar stimulation in children and adults with cerebral palsy has resulted in worthwhile improvement. It is important to remember that it has reduced spasticity and that any improvement is a result of the patient's residual motor abilities.

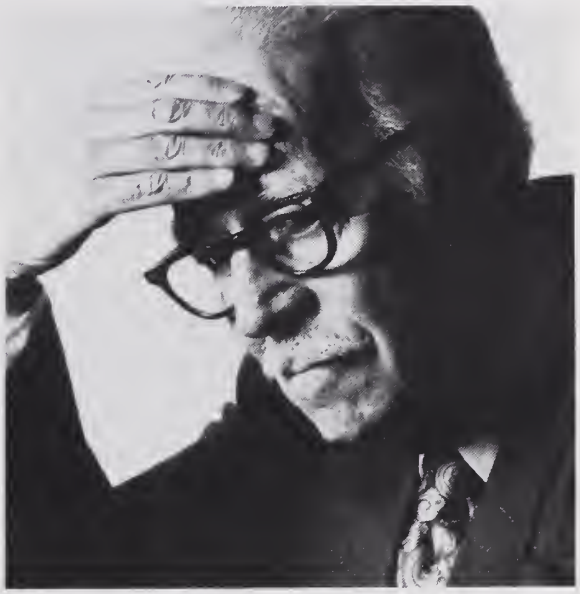
References

1. Cooper, I. S.; Amin I; Gilman, S., and Waltz, J. M.: The Effect of Chronic Stimulation of Cerebellar Cortex on Epilepsy in Man. P. 119-171 in "The Cerebellum, Epilepsy and Behavior" ed by Cooper, I. S.; Riklan, M., and Snider, R. S., 1973.
2. Cooper, I. S.: Chronic Stimulation of Paleocerebellar Cortex in Man, Lancet 1:206, 1973.
3. Davis, R. and Gesink, J. W.: Evaluation of Electrical Stimulation as a Treatment for the Reduction of Spasticity, Bull. Proseth. Res. 302-309, Fall 1974.

▶Dr. Davis, 4300 Alton Road, Miami Beach 33140.

Actual difficulties can be overcome, only the imaginary ones seem unconquerable.

A TOTALLY NEW DELIVERY SYSTEM TO **HELP REDUCE THE FEAR OF ANGINAL ATTACKS**



Round-the-clock protection with

ISO-BID

(ISOSORBIDE DINITRATE)

40 mg. capsules ... twice-a-day dosage

Controlled sustained release of ISO-BID's isosorbide dinitrate through micro-dialysis diffusion can help reduce frequency and intensity of anginal attacks. This in turn can minimize patient's fear of attacks, and dependence on nitroglycerin.

Unlike ordinary sustained release products, ISO-BID releases isosorbide dinitrate at a smooth, continuous, predictable, controlled rate to provide for up to 12 hours of therapeutic activity. Micro-dialysis is dependent only upon the presence of fluid in the G.I. tract and not on pH or other variables. ISO-BID is particularly advantageous in the prevention of nocturnal angina.

DOSAGE: One ISO-BID capsule every 12 hours on an empty stomach according to need, for continuous 24-hour therapy. Some patients may require higher dosage levels. In these patients, dosage should be titrated, and they may require two ISO-BID capsules b.i.d. Not intended for sublingual use. Consult product brochure before prescribing.

THERAPEUTIC FOOTNOTE: IN TREATING ANGINA . . . FAILURES MAY RESULT FROM INADEQUATE DOSAGE
Reports in the literature indicate the usefulness of higher dosage levels of isosorbide dinitrate.[1,2]

INDICATIONS: Based on a review of this drug by the National Academy of Sciences — National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: For the relief of angina pectoris (pain of coronary artery disease). ISO-BID is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris. Final classification of the less-than-effective indication requires further investigation.

CONTRAINDICATION: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Use with caution in patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

SAMPLES AND LITERATURE AVAILABLE.

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PIONEERS IN GERIATRIC RESEARCH
DEVELOPERS AND SUPPLIERS OF CEVI-BID • GER-O-FOAM • TESTAND-B

1. Shane, S.J.: Canadian Family Physician, November 1973. 2. Lemberg, L.: Practical Cardiology, February 1976.

WILL POWER

Through your will you have the power to help fight the heart diseases that will cause one out of every two deaths this year.

Remember your Heart Association so someone else may enjoy the precious gift of life.

For more information ask your attorney or your Heart Association.



We were lucky she took the job.

The President's Committee on Employment of the Handicapped

The School of Visual Arts Public Advertising System

LIBRIUM®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

EXPERIENCE. STILL YOUR HIGHEST AUTHORITY.

The discovery of Librium at Hoffmann-La Roche represented a landmark in psychotherapeutics. And, more specifically, a landmark in the treatment of anxiety and anxiety-related conditions.

Today, the acceptance of Librium by the medical community is based firmly on experience. And on a well-documented clinical record.

A record so voluminous it had to be put into a computerized storage and retrieval system.

Take the matter of safety, for example.

Experience with millions of patients indicates that the most common side effects of Librium are dose-related and, therefore, largely avoidable. There appears to be a low potential for dependence. Tolerance rarely develops. Few cases of known toxicity have been reported. However, patients should be cautioned about possible combined effects with alcohol and other CNS depressants.

Librium seldom produces adverse effects on the cardiovascular or respiratory



system. It is used concomitantly with many primary medications, such as cardiac glycosides, antihypertensive agents, anticholinergics, diuretics, antacids and anticoagulants. It should be noted that variable effects on blood coagulation have been reported very rarely in patients receiving Librium and oral anticoagulants; however, a causal relationship has not been established clinically.

Experience. Yours and ours. Together they make the task of choosing an antianxiety agent much simpler.

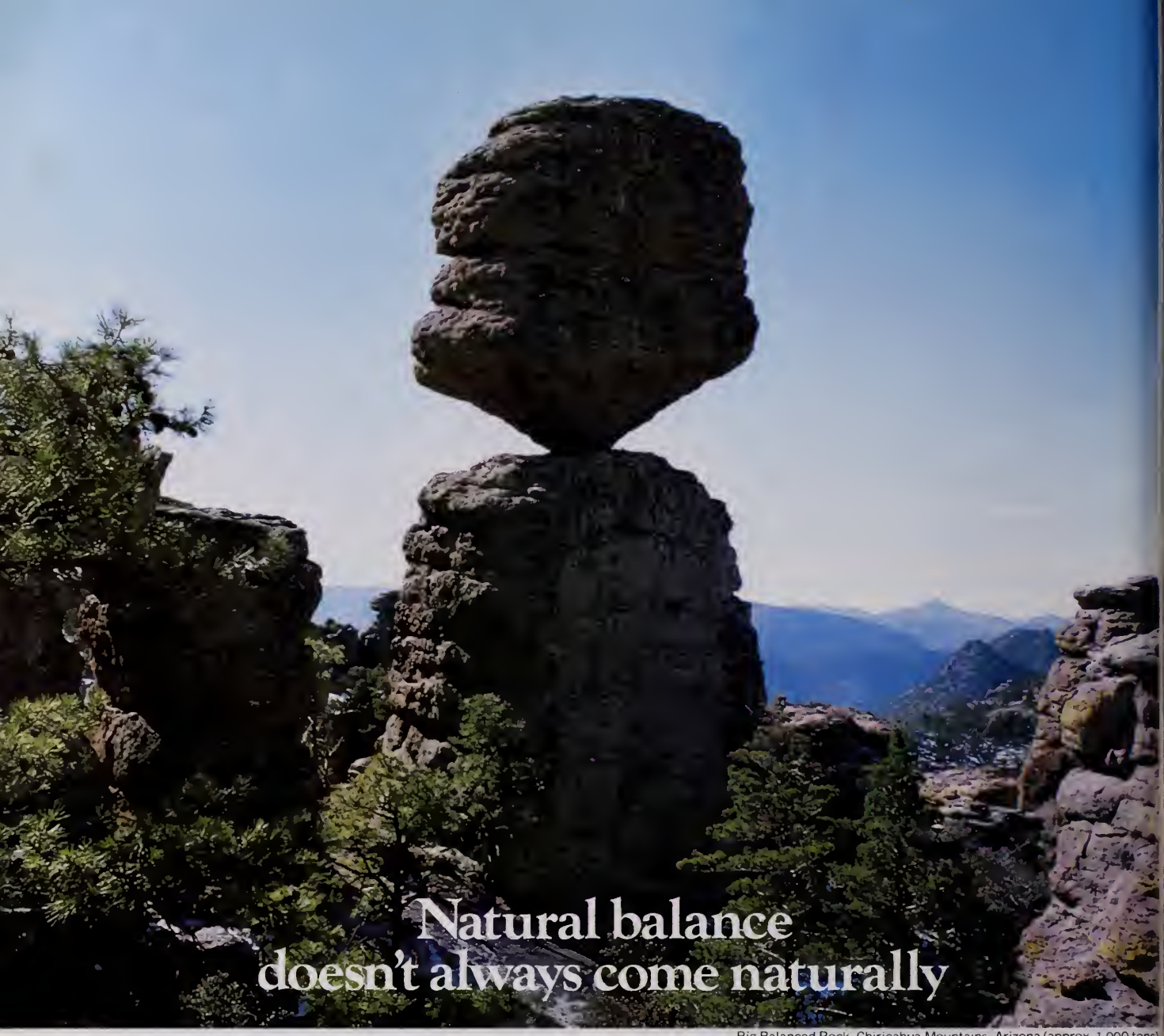
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chlordiazepoxide HCl/Roche

ROCHE

THE ANXIETY-SPECIFIC

Please see summary of product information on opposite page.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

ORGANIZATION

Summary of FMA Board of Governors Meeting

October 6-9, 1976

The following is a summary of the actions taken by the Board of Governors at its meeting on October 6-9,1976.

FMA PROGRAM PRIORITIES 1976-77

The Board:
Adopted the following FMA Program Priorities 1976-77 and directed that all available financial and staff resources be utilized in carrying out these programs:

1. Special emphasis on liaison with county medical societies and the development of new, more effective communications with the FMA membership
2. Indepth implementation of a comprehensive statewide public relations program
3. Continued emphasis on coordination of legislative activities with the county medical societies
4. Continued active support of FLAMPAC
5. Statewide health planning activities
 A. Emphasis on liaison with the Department of Health and Rehabilitative Services
 B. Continued encouragement of county medical societies to insure physician participation in the development of HSA's
 C. Representation on and input in the State Health Coordinating Council
 D. Development of adequate safeguards in the collection and utilization of health data and the protection of the confidentiality of such information
6. Continued efforts to establish a statewide peer review organization in the private sector to conduct current review programs and also to serve as a data support center
7. Emergency Services—Emergency Medical Services
 A. Establishment of a statewide emergency medical services network
 B. Establishment of standards for optimal critical care facilities
 C. Active support of CPR Life Support Training Programs
8. Continued efforts in the areas of physician availability, cost of medical care and nursing homes.

CALLED MEETING OF HOUSE OF DELEGATES

Directed that the FMA President initiate a called meeting of the House of Delegates January 28-30, 1977, in Orlando at the Dutch Inn (subject to satisfactory arrangements being made).

1977 CALLED MEETING FORMAT

Approved the following format for the called meeting of the House of Delegates January 28-30, 1977, to include an informational section for for CMS officers during the General Session.

Friday, January 28:
12:30 p.m. General and Delegates Registration
2:00 p.m. First House of Delegates

Saturday, January 29:
9:00 a.m. Reference Committee I (Legislation) and Reference Committee II (Miscellaneous Business)
2:00 p.m. General Session
6:30 p.m. Reception

Sunday, January 30:
9:00 a.m. Second House of Delegates

1977 ANNUAL MEETING FORMAT

Approved the 1977 Annual Meeting format.

Wednesday, May 4:
Set up Exhibits

10:00 a.m. General and Delegates Registration

1:00 p.m. -
4:15 p.m. *Scientific Sections*
4:30 p.m. -
5:30 p.m. First House of Delegates

Thursday, May 5:
8:00 a.m. Blue Shield Annual Meeting
10:00 a.m. Ref. Comm. Nos. V & I
10:30 a.m. Ref. Comm. Nos. IV & Ii
11:00 a.m. Ref. Comm. No. III
Visit Exhibits - 8:30 a.m. - 4:30 p.m.

1:30 p.m. -
5:30 p.m. *Scientific Sections*
(Reference Committees if Necessary)

Friday, May 6:
8:00 a.m. - *Scientific Sections* &
10:45 a.m. Specialty Groups

Visit Exhibits - 8:30 a.m. - 4:30 p.m.

11:30 a.m. General Session (Baldwin Lecture)
12:15 p.m. - Auxiliary & FLAMPAC Luncheon

2:00 p.m. -
5:30 p.m. *Scientific Sections*
6:30 p.m. -
7:30 p.m. President' Reception

Saturday, May 7:
8:00 a.m. - Specialty Groups &
12:30 p.m. - *Scientific Sections*

Visit Exhibits - 8:30 a.m. - 4:30 p.m.

1:00 p.m. - Specialty Groups &
2:45 p.m. - *Scientific Sections*
3:00 p.m. - Second House of Delegates

Dismantie Exhibits
Specialty Groups Socials

Sunday, May 8:
9:00 a.m. Third House of Delegates

Post Convention Board Meeting

COUNCIL ON SCIENTIFIC ACTIVITIES

Approved scientific program presented by J. Lee Dockery, M.D., Chairman of the Council on Scientific Activities which will allow physicians to obtain up to 20 hours CME mandatory credit at the FMA 1977 Annual Meeting.

HOUSE OF DELEGATES RATIO

Approved the current ratio in the House of Delegates of one delegate for each forty active members be maintained for another year.

1979 ANNUAL MEETING

Voted to hoid the *1979* FMA Annual Meeting in the Orlando area subject to satisfactory arrangements being made.

APPOINTMENT ASSISTANT EDITOR *FMA JOURNAL*

Approved appointment of Edward W. St. Mary, M.D., Miami, as an Assistant Editor for the *FMA Journal.*

LEGAL DEFINITION OF DEATH

Approved the principles embodied in a proposed statement regarding a legai definition of death to be submitted to the House of Delegates for consideration:

"It appears that Florida Law has not undertaken to define death, except as to fetai death, but has impliedly ieft such determination to the physician based on the prevailing medical standard and the facts of the specific case."

DEATH WITH DIGNITY

Reaffirmed the previous FMA position on death with dignity adopted by the House of Deiegates in 1974.

FLORIDA HEALTH DATA CORPORATION

Approved the FMA's participation in the Florida Health Data Corporation. The purpose of this Corporation is a joint effort by the FMA, Florida Hospital Association and Florida Osteopathic Medical Association to establish and operate an independent health data bank *controlled by the private sector.*

MEDICAID

Adopted a policy statement regarding Florida's Medicaid program to be submitted to the House of Delegates.

Commend those members who are participating in the Medicaid program and urge continued participation.

Urge improvement in HRS computer capability and data retrieval to achieve patient, physician, and institution profile.

Identify abuse if and where it exists whether patient, physician or institution -- investigate and prosecute where indicated.

If and when physician abuse is found or suspected, use the FMA Peer Review Program to correct the program.

CUT-RATE MEDICAL TESTING CENTERS

Directed FMA Legal Counsel to investigate possible legal recourse regarding cut-rate medical testing centers in Florida and that this be done in cooperation with the Attorney General.

POLICY STATEMENT HOSPITAL STAFF PRIVILEGES

Approved a policy statement regarding hospital staff privileges for non-physicians to be submitted to the House of Delegates for consideration.

PAP SMEARS

Encouraged all government medical care programs and third parties including Blue Shield to consider Pap Smears as a necessary medical procedure and that reimbursement be made to physicians for this procedure.

SPECIALTY DESIGNATIONS IN YELLOW PAGE LISTINGS

Received a report indicating the full cooperation of Southern Bell in abiding by the FMA approved specialty listings for telephone directory yellow page advertising as approved by the House of Delegates at its meeting February 1976.

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT - STATE HEALTH PLANNING AGENCY

Opposed full designation of the Department of HRS as the State Health Planning and Development Agency under PL 93-641, and reaffirmed the previous decision of the House of Delegates to proceed with development of a PRO program working within the private sector.

SOCIAL SECURITY NUMBERS

Received a report advising that the resolution submitted by the California Medical Society regarding Social Security numbers which was previously approved by the Board was subsequently approved by the AMA House of Delegates at its meeting in July. The resolved of this resolution expresses opposition to the use of the Social Security number as a universal identifier.

FRANCIS T. HOLLAND, M.D.

Expressed appreciation to Francis T. Holland, M.D., Tallahassee, for his many years of service to the FMA as Chairman of Florida's Delegation to the AMA. Dr. Holland's term as AMA delegate expires Dec. 31, 1976, and he did not seek re-election. He has served as a delegate for 22 years. Dr. Holland was elected Vice President of AMA at its annual meeting in July.

DEFINITION OF AN ALLIED HEALTH PROFESSION

Revised the FMA definition of an allied health care profession to include those groups whose members are involved in/or educated in a *professional* field and to substitute the term *health care* in place of medical care.

CRITERIA FOR RECOGNITION OF AN ALLIED HEALTH PROFESSION

Approved expansion of the criteria for recognition of an allied health profession to require any group requesting recognition *to have been in existence for a period of five years.* Other criteria includes:

1. That a group requesting recognition be organized on a statewide level, or have the potential to do so.

2. That it be endorsed by the Florida Medical Association component group with which it most closely associates (when one exists).

3. That its purpose and needs are not covered or in conflict with an already existing organization.

4. That its structure will assist and not deter other related groups.

5. That a preliminary constitution and/or bylaws state its organizational structure, purposes and aims.

FMA RECOGNITION OF ALLIED HEALTH PROFESSIONS

Granted FMA recognition of the following allied health professions: Florida Academy of Physician's Assistant's; and Florida Society for Respiratory Therapy. This brings the total of recognized groups to 13.

NURSE PRACTICE ACT

Recommended major modifications to the proposed rules and regulations for the new Nurse Practice Act to assure physician supervision of the nurse practitioner, and requested the Board of Medical Examiners to investigate any nurse practitioner currently practicing in an independent setting and take appropriate action.

FMA DIRECTORY

Approved expansion of the section on FMA recognized voluntary health agencies in the Florida Medical Directory to include information on the services and programs available through these organizations.

COMMITTEE ON SPORTS MEDICINE

Designated the FMA's special Committee on Sports Injuries as a standing committee of the FMA under the Council on Medical Services and approved a change of Committee's name to the Committee on Sports Medicine.

SCHOOL TRAMPOLINE INJURIES

Voted to notify the Department of Education that the FMA has changed the policy adopted by the Florida School Health Medical Advisory Committee in 1974 regarding trampolines to provide:

'It is the opinion of the Florida Medical Association's Committee on Sports Medicine that trampolines are *unsafe* even under supervised conditions.'

CURRICULUM FOR PHYSICAL EDUCATION MAJOR

Recommended to the Board of Regents that courses in athletic training be part of the required curriculum for physical education majors.

DIABETES SCREENING PROGRAM

Endorsed the Diabetes Screening Program of the Florida Cooperative Extension Service.

COUNTY HEALTH DEPARTMENTS

Expressed continued support for a substantial increase in state funding for county health departments.

SCOLIOSIS SCREENING

Recommended to the Department of Health and Rehabilitative Services that screening for scoliosis be incorporated as part of a school screening program.

COUNCIL ON MEDICAL SERVICES

Commended the Council on Medical Services and its Committees for outstanding work in areas of major importance to the Association:

The Committee on Drug Abuse chaired by Dr. Robert P. Johnson, of Tallahassee, recently concluded an on-site evaluation of medical care in the state's 29 residential drug abuse treatment centers. This was done through a contract with the Department of HRS, Bureau of Drug Abuse.

The Committee on Emergency Medical Services chaired by Dr. Arthur L. Trask, of Boynton Beach, recently concluded a successful Conference on the Identification of Needs and Standards for In-Hospital Critical Care. This Conference was sponsored by the Florida Medical Foundation through a grant from the Emergency Medical Services Section of the Health Program Office.

DONN L. SMITH, M.D.

Commended Dr. Donn Smith for his outstanding work as Dean of the University of South Florida, School of Medicine and wished him success in his future endeavors upon stepping down from his post.

STATE BOARD OF MEDICL EXAMINERS

Expressed support for the Board of Medical Examiners in its effort to gain additional budgetary increases for administrative staff.



Others Are Saying

Middle Class a Sensible Society

In a sensible society, those who by their own efforts relieve the state of liability to support them in ill health, infirmity or old age, or to supply them with other benefits that it dispenses to the needy, ought obviously to be encouraged. Private pension arrangements should be favoured, and tax advantages should be given, up to a limit, to those who spend their own money on education or health service which otherwise the Government would have to provide. Far from this happening in 1976, the envious pursuit of a mythical equality is more and more penalizing private medicine and independent education, both of which, indeed, the levellers would like to extinguish, thereby destroying two personal freedoms peculiarly precious to many of the middle class.

Lees M. Schadel, Jr., M.D.
Editor, The Record

Reprinted from The Record, Broward County Medical Association, March 1976.

Dr. Schadel is Editor of The Record and a Consulting Editor to the Journal of the Florida Medical Association.

It is the individual who knows how little he knows about himself who stands a reasonable chance of finding out something about himself before he dies.

S. I. Hayakawa

Patient Recall

Research has shown that patients often remember very little of the medical conversations which have taken place between them and their physician—a matter of psychologic and legal concern to the doctor.

At Albert Einstein College of Medicine, Dr. George Robinson, professor of surgery, conducted a study on patients who underwent open heart surgery. The patients not only forgot extensive portions of pre-operative, tape-recorded conversations with their surgeons but often fabricated details and some, in fact, denied having had an informed consent discussion.

Patients averaged recalling less than a third of what the surgeon discussed with them, and even under prompting, the recall score was only 45 per cent four to six months after surgery.

The medico-legal implications of this study buttress what occurs daily in physician offices throughout the country.

From personal experience it may be observed that patients, after intensive investigation and treatment, will contend that I have told them nothing. Yet, extensive conversation was held and, at the time, I felt that I had been understood.

Obviously, communications at best are difficult. This makes documentation of informed consent increasingly important. And we should exercise a certain understanding when the patient contends that "you told me nothing;" for this may be interpreted to mean that he or she did not feel the physician had the final answer or did not say what was wanted and expected.

We should understand, too, that when a patient contends that another physician told him or her nothing that the process is being repeated and we, ourselves, may be the subject of similar reports.

In summation, the physician should always utilize tapes and other documentation for patient discussions, and particularly those involving patient consent.—F.N.V.

Reprinted from the Escambia County Medical Society Bulletin, May 1976.



CIRCUBID® ethaverine hydrochloride 150mg.

for cerebral & peripheral circulation

Circubid (ethaverine hydrochloride) is logical geriatric medicine. Safe for longterm use, Circubid may relieve both cerebral and peripheral vasospasm through direct relaxation. Circubid is an active ethyl homologue of papaverine. The prolonged release affords a simplified dosage regimen and continous benefits.

ACTION: Ethaverine HCl. acts directly on the smooth muscle cells without involving the autonomic nervous system or its receptors.

INDICATIONS: In peripheral and cerebral vascular insufficiency associated with arterial spasm, in spastic conditions of the gastro-intestinal and genito-urinary tracts.

CONTRAINDICATIONS: Contraindicated in the presence of complete atrioventricular dissociation.

PRECAUTIONS: It should be administered with caution in patients with glaucoma. It should not be used in pregnant women or in women of childbearing age unless directed by a physician.

ADVERSE REACTIONS: Even though the incidence of side effects as reported in literature is very low, it is possible for a patient to evidence nausea, anorexia, abdominal distress, dryness of the throat, hypotension, flushing, sweating, vertigo, respiratory depression, cardiac depression, cardiac arrhythmia and headache. If these side effects occur, reduce dosage or discontinue medication.

DOSAGE: The usual adult dose is 300 mg. daily, one capsule every 12 hours. In more difficult cases the dosage may be increased to 600 mg. daily as determined by the physician. It is most effective given early in the course of the vascular disorder. Because of the chronic nature of the disease long term therapy is required.

SUPPLIED: Each green and clear capsule contains ethaverine hydrochloride 150 mg., manufactured to provide a prolonged therapeutic effect.

W. F. MERCHANT
PHARMACEUTICAL COMPANY, INC.
WARRENTON, VIRGINIA 22186

MERCHANT

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ORGANIZATION

Journal Wins Major Award in Statewide Contest

A special issue of **The Journal of The Florida Medical Association** has been cited as best in its category in the annual awards contest sponsored by the Florida Magazine Association.

The "Special Issue on Dermatology," published by JFMA in January, 1976, was announced as the top winner in a field of 12 entries in the special issue category at the conclusion of the Magazine Association's 24th Annual Convention at Sarasota on September 11.

Entries were evaluated by a panel of 12 judges consisting of faculty of the University of Florida's College of Journalism and Communications, and out-of-state experts.

"This issue on the scope of dermatology is fantastic," the judges stated in a published critique. "This special issue had everything a good special issue should — a clear table of contents, a logical introduction or lead article explaining 'why do it,' many articles covering the various aspects of the issue, logical order to the articles, and references with each article."

The Florida Sportsman and the **Florida Bar Journal** were among several publications which had entered the "best special issue" category. JFMA's award was an attractive inscribed plaque.

JFMA also collected Certificates of Merit in the general excellence category for non-profit association publications of less than 18,000 circulation and in the "best historical perspective feature" division. Honored in the latter category was the article, "Killer 'Canes and Medical Care," by JFMA Historical Editor William M. Straight, M.D., which was published in the August 1975 Historical Issue.

"Reflecting its solid professional approach, this journal maintains dignified stance by adhering to formal study and document-of-record presentations," the judges stated in a general comment. "Overall, a professionally produced publication for professionals."

The dermatology issue was one of the most intricate projects undertaken by JFMA in recent years. Many months in preparation, it consisted of papers prepared by members of the Florida Society of Dermatology.

Charles C. Dugan, M.D., of West Palm Beach, and Morris Waisman, M.D., of Tampa, worked long and hard as Guest Editors.

The awards were accepted on behalf of the FMA by Mr. Edward D. Hagan, Executive Editor of **The Journal.** Earlier, Mr. Hagan was elected to the Board of Directors of the Magazine Association, whose membership consists of editors and publishers of more than 80 journals and other magazines published in Florida.

Preliminary Program

103rd Annual Meeting Scientific Program

One of the most expansive scientific programs in the century-long history of the Florida Medical Association will await physicians attending the 1977 Annual Meeting.

Almost all of FMA's 35 recognized specialty societies will participate in the scientific program which will feature 35 sections, according to O. Frank Agee, M.D., of Gainesville, who is serving his second year as General Program Chairman.

The five-day meeting will get underway at the Americana Hotel in Bal Harbour on Wednesday, May 4, 1977, with a "Symposium on the Medical and Surgical Approaches to Stroke."

Symposium Co-Chairmen Michael J. Pickering, M.D., of Tampa, and Daniel B. Nunn, M.D., of Jacksonville, said the stroke symposium is designed to appeal to physicians of many specialties. Speakers are to include:

Jesse E. Thompson, M.D., Professor of Surgery, University of Texas Southwestern Medical School, Dallas, Texas; L. James Wilmore, M.D., Assistant Professor of Neurology, University of Florida College of Medicine, Gainesville; and Hiram B. Curry, M.D., Professor and Chairman of the Department of Family Practice, Medical University of South Carolina, Charleston.

Dr. Agee said there will be scientific programs Wednesday and Thursday afternoons, May 4-5; all day Friday, May 6; and Saturday morning and part of Saturday afternoon, May 7.

Physicians may earn up to 20 hours of "mandatory" continuing medical education credit under the FMA program, or a full year's quota in that category, according to Dr. Agee. Application will be made for an equal amount of AMA Category I credit hours and for an appropriate amount of American Academy of Family Physicians Prescribed hours.

Following is a scientific program timetable with program details available as **The Journal** went to press. Other section programs will be published as they become available in subsequent issues:

WEDNESDAY AFTERNOON—MAY 4

SYMPOSIUM ON THE MEDICAL AND SURGICAL APPROACHES TO STROKE
(Sponsored by FMA Committee on Continuing Medical Education)
Wednesday—1:00 p.m. to 2:30 p.m.
Michael J. Pickering, M.D., Tampa
Daniel B. Nunn, M.D., Jacksonville
Program Co-Chairmen

Opening Remarks—Daniel B. Nunn, M.D., Jacksonville

"Surgical Approach to Stroke," Jesse E. Thompson, M.D., Professor of Surgery, University of Texas Southwestern Medical School, Dallas, Texas

"Medical Approach to Stroke," L. James Wilmore, M.D., Assistant Professor of Neurology, University of Florida College of Medicine, Gainesville

"General Practice Approach to Stroke," Hiram B. Curry, M.D., Associate Professor of Neurology and Professor and Chairman, Department of Family Practice, and Director, Residency Training Program in Family Practice, Medical University of South Carolina, Charleston, S.C.

Questions and Answers

Adjournment

SECTION ON INTERNAL MEDICINE
(Co-sponsored by American College of Physicians and Florida Society of Internal Medicine)
Wednesday—2:45 p.m. to 4:15 p.m.
Michael J. Pickering, M.D., Tampa
Program Chairman
"Use and Abuse of Antibiotics"

Opening Remarks—Charles P. Craig, M.D., Associate Professor of Medicine, University of South Florida College of Medicine

"Limitations of Newer Antibiotics," Herbert L. DuPont, M.D., Professor of Medicine, University of Texas Medical School at Houston

"Adverse Effects of Antibiotics," Harold Neu, M.D., Professor of Medicine, Columbia University College of Physicians and Surgeons, New York

"Preventive Antibiotics," Calvin M. Kunin, M.D., Professor of Medicine, University of Wisconsin Medical School, Madison

Questions and Answers

Adjournment

THURSDAY AFTERNOON—MAY 5

SECTION ON NEUROLOGY
(Co-sponsored by Florida Society of Neurology)
Thursday—1:30 p.m. to 5:30 p.m.
Manuel J. Mier, M.D., Venice
Program Chairman

"Electromyography," Joel Brumlik, M.D., Professor and Chairman, Department of Neurology, Loyola University Stritch School of Medicine, Maywood, Ill.

"Computer Tomography," Jerome J. Sheldon, M.D., Chief of Neuro-Radiology, Mt. Sinai Medical Center, Miami Beach, and Professor of Radiology, University of Miami School of Medicine, Miami

"Electronic Implants," Ross Davis, M.D., Chief of Neurological Surgery, Mt. Sinai Hospital Medical Center, Miami Beach

"Echoencephalography," Manuel J. Mier, M.D., Director of the Neurology Laboratory, Venice Hospital, Venice

Adjournment

SECTION ON RHEUMATOLOGY
(Co-sponsored by Florida Society of Rheumatology)

Thursday—1:30 p.m. to 5:00 p.m.

Richard Panush, M.D., Gainesville
Program Chairman

"Gout and Pseudogout," John Talbott, M.D., Clinical Professor of Medicine, University of Miami School of Medicine, and Editor, **Seminars in Arthritis and Rheumatism**, Miami

Questions and Answers

"A New Home Management System for Arthritic Patients," Gerald H. Stein, M.D., Assistant Professor of Medicine and Community Medicine, University of Florida College of Medicine, Gainesville

Questions and Answers

"Non-Articular Rheumatism," Charles M. Plotz, M.D., Med. Sc.D., Professor of Medicine, Downstate Medical Center, Brooklyn, N.Y.

Questions and Answers

Break

"Spondyloarthritis and HLA-B27," Selden Longley, M.D., Assistant Professor of Medicine, University of Florida College of Medicine, Gainesville

Questions and Answers

"Outpatient Management of Rheumatoid Arthritis," Bernard F. Germain, M.D., Chief, Rheumatology Division, University of South Florida School of Medicine, Tampa

Questions and Answers

Panel Discussion (all speakers)

Adjournment

SECTION ON PSYCHIATRY
(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

Thursday—1:30 p.m. to 4:30 p.m.

Samuel I. Greenberg, M.D., Miami
Program Chairman

Speakers and topics related to "Current Psychiatric Drug Usage" to be announced

Adjournment

SECTION ON FAMILY PRACTICE
(Co-sponsored by Florida Academy of Family Physicians)

Thursday—2:00 p.m. to 5:00 p.m.

D. Robert Howard, M.D., Tampa
Program Chairman

Speakers and Topics to be Announced

SECTION ON CHEST MEDICINE
(Co-sponsored by Florida Chapter, American College of Chest Physicians and Florida Thoracic Society)

Thursday—2:00 p.m. to 5:00 p.m.

Roberto Llamas, M.D., Miami Beach
Gerald Olsen, M.D., Jacksonville
Program Co-Chairmen

"Recent Advances in Lung Cancer"

Moderator: Wilbur Avery, M.D., Chief, Pulmonary Diseases, South Miami Hospital, South Miami

"Work-up, Indications for Surgery Results," Thomas B. Ferguson, M.D., Clinical Professor of Cardiothoracic Surgery, Washington University School of Medicine, St. Louis, Mo.

"Pre-operative Functional Evaluation," Gerald Olsen, M.D., Medical Director of Pulmonary Medicine, St. Vincent's Medical Center, Jacksonville

"Early Diagnosis," David Solomon, M.D., Staff Physician and Assistant Professor of Medicine, Pulmonary Diseases Section, Department of Internal Medicine, University of South Florida College of Medicine and Tampa Veterans Administration Hospital, Tampa

"Radiology," Luis Martinez, M.D., Associate Director of Radiology, Mt. Sinai Medical Center, Miami Beach, and Professor of Radiology, University of Miami School of Medicine, Miami

"Drug Regimens, Immunotherapy, New Developments," Oleg Selawry, M.D., Chief, Division of Lung Cancer, and Professor, Department of Oncology, Comprehensive Cancer Center, University of Miami School of Medicine, Miami

Adjournment

FRIDAY MORNING—MAY 6

DIALOGUE
(Presented through the courtesy of Pfizer Laboratories)

Friday—Time to Be Announced

Each one-hour segment of Dialogue will begin with a five or ten-minute overview of a topic of current interest by a guest speaker. The remainder of each hour will include audience questions.

Dialogue I —Speaker and Subject to be Announced
Dialogue II—Speaker and Subject to be Announced

SECTION ON BASIC LIFE SUPPORT CERTIFICATION
SECTION I
(Co-sponsored by Florida Chapter, American College of Emergency Physicians and Florida Society of Anesthesiologists)

Friday—8:00 a.m. to 10:45 a.m.

Program to be Announced

SECTION ON NEONATAL PERINATOLOGY
(Co-sponsored by Florida Chapter, American Academy of Pediatrics, Florida Pediatric Society, and Florida Society of Neonatal-Perinatologists)

Friday—8:00 a.m. to 10:45 a.m.

Charles Bauer, M.D., Miami
James A. Hallock, M.D., Tampa
Program Co-Chairmen

"Regionalization of Perinatal Care"

Introduction and Welcome — Charles R. Bauer, M.D., President, Florida Society of Neonatal-Perinatologists, Miami.

"The Goals of Perinatal Regionalization," Allan G. W. McLeod, M.D., Professor of Obstetrics and Gynecology, University of Miami School of Medicine, Miami.

"The Need for Educational Leadership in the Regional Perinatal Program," Donald V. Eitzman, M.D., Professor of Pediatrics, University of Florida College of Medicine, Gainesville.

"Cooperation Between Various Levels of Perinatal Care," Ellen F. Monkus, M.D., Ph.D., Associate Professor of Pediatrics, University of Miami School of Medicine, Miami.

Questions and Answers — Drs. McLeod, Eitzman and Monkus

Coffee Break

"Appropriate Transportation of Mothers and Infants," Howard Harris, M.D., Assistant Professor of Pediatrics, University of South Florida College of Medicine, Tampa.

"Long-Term Evaluation in the Perinatal Program," Edmund A. Egan II, M.D., Assistant Professor of Pediatrics, University of Florida College of Medicine, Gainesville.

"Future of the Perinatal Program—Legislative Action," Julia C. R. St. Petery, M.D., Director, Office of Children's Medical Services, Department of Health and Rehabilitative Services, Tallahassee.

Questions and Answers — Drs. Harris, Egan and St. Petery.

Adjournment

SECTION ON NUCLEAR MEDICINE AND FAMILY PRACTICE
(Co-sponsored by Florida Association of Nuclear Physicians and Florida Academy of Family Physicians)

Friday—8:00 a.m. to 10:45 a.m.

Aldo N. Serafini, M.D., Miami Beach
D. Robert Howard, M.D., Tampa
Program Co-Chairmen

"Noninvasive Diagnostic Techniques in Clinical Practice For The Family Physician"

Welcome and Opening Remarks — D. Robert Howard, M.D., Professor and Chairman, Department of Family Medicine, University of South Florida College of Medicine, Tampa.

"The Evaluation of the Jaundiced Patient—The Role of Abdominal Ultrasound," Noel R. Zusmer, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Tumor Detection and Staging with Radioisotopes," Lawrence R. Muroff, M.D., Clinical Assistant Professor of Radiology, University of South Florida College of Medicine, Tampa

"Modern Therapeutic Trends in Oncology," Michael Troner, M.D., Assistant Professor of Medicine, Division of Oncology, University of Miami School of Medicine and Veterans Administration Hospital, Miami

"Nuclear Cardiology," Aldo N. Serafini, M.D. Assistant Professor of Radiology, Division of Nuclear Medicine, Mount Sinai Medical Center, Baumritter Institute of Nuclear Medicine, Miami Beach.

"Pulmonary Embolism and Deep Vein Thrombosis—Detection and Treatment," Edward A. Eikman, M.D., Assistant Professor of Medicine, University of South Florida College of Medicine, and Chief, Nuclear Medicine Service, Veterans Administration Hospital, Tampa

Questions and Answers

Adjournment

FRIDAY AFTERNOON—MAY 6

DIALOGUE
(Presented through the courtesy of Pfizer Laboratories)

Each one-hour segment of Dialogue will begin with a five or ten-minute overview of a topic of current interest by a guest speaker. The remainder of each hour will include audience questions.

Dialogue III—Speaker and Subject to be Announced
Dialogue IV—Speaker and Subject to be Announced

SECTION ON OTOLARYNGOLOGY
(Co-sponsored by Florida Society of Otolaryngology)

Friday—1:30 p.m. to 5:30 p.m.

Herbert Fields, M.D., North Miami Beach
Program Chairman

"Thyroid Surgery" (Panel)—Speakers to be announced.

"Current Treatment of Sinus Disease" (Panel)—Speakers to be announced.

Adjournment

SECTION ON COLON AND RECTAL SURGERY
(Co-sponsored by Florida Society of Colon and Rectal Surgeons)

Friday—1:30 p.m. to 4:30 p.m.

Manuel L. Carbonell, M.D., Miami
Program Chairman

Speakers and Topics to be Announced

SECTION ON BASIC LIFE SUPPORT CERTIFICATION
SECTION II
(Co-sponsored by Florida Chapter, American College of Emergency Physicians and Florida Society of Anesthesiologists)

Friday—2:00 p.m. to 5:00 p.m.

Program to be Announced

SECTION ON ENDOCRINOLOGY
(Co-sponsored by Florida Endocrine Society)

Friday—2:00 p.m. to 5:00 p.m.

Lawrence M. Fishman, M.D., Miami
Program Chairman

Program to be Announced

SECTION ON ORTHOPEDIC SURGERY
(Co-sponsored by Florida Orthopedic Society)

Friday—2:00 p.m. to 5:30 p.m.

Richard G. Onkey, M.D., Naples
Program Chairman

Program to be Announced

SECTION ON NEPHROLOGY
(Co-sponsored by Florida Society of Nephrology)

Friday—2:00 p.m. to 5:00 p.m.

Robert A. Metzger, M.D., Orlando
Program Chairman

Program to be Announced

SECTION ON PREVENTIVE MEDICINE
(Co-sponsored by Florida Society for Preventive Medicine)

Friday—1:30 p.m. to 5:00 p.m.

James T. Howell, M.D., Palm Springs
Program Chairman

"Influenza—Past, Present and Future," E. Charlton Prather, M.D., M.P.H., Director, Health Program Office, Department of Health and Rehabilitative Services, Tallahassee

"Current Communicable Disease Problems at the Center for Disease Control and Update on Smallpox Eradication," Stanley Music, M.D., Center for Disease Control, Atlanta, Ga.

Break

"Modern Tuberculosis Treatment," Clifford Cole, M.D., Director of Community Tuberculosis Program Services, Department of Health and Rehabilitative Services, Jacksonville

"Current Cardiovascular Risk Factor Reversal Programs and Update on the Mr. Fit Program," George Christakis, M.D., M.P.H., Professor of Public Health and Epidemiology, University of Miami School of Medicine, Miami

Questions and Answers

Adjournment

SECTION ON PEDIATRICS
(Co-sponsored by Florida Chapter, American Academy of Pediatrics, and Florida Pediatric Society)

Friday—2:00 p.m. to 5:30 p.m.

James A. Hallock, M.D., Tampa
Program Chairman

Program to be Announced

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY
(Co-sponsored by Florida Society of Thoracic Surgeons)

Friday—2:00 p.m. to 4:00 p.m.

Daniel B. Nunn, M.D., Jacksonville
Program Chairman

"Physiologic and Surgical Considerations of the Coronary Circulation," David C. Sabiston, M.D., James B. Duke Professor and Chairman, Department of Surgery, Duke University School of Medicine, Durham, N.C.

"Medical and Surgical Treatment of Coronary Artery Disease" (Panel)

Moderator:

Daniel B. Nunn, M.D., Clinical Assistant Professor of Surgery, Division of Thoracic and Cardiovascular Surgery, University of Florida College of Medicine (JHEP), and Chief of Thoracic and Cardiovascular Surgery, Methodist Hospital, Jacksonville

Panelists:

Edward Spoto, Jr., M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa

Clifford R. Guy, M.D., Clinical Assistant Professor of Medicine, Division of Cardiology, University of Florida College of Medicine (JHEP), Jacksonville

Thomas O. Gentsch, M.D., Clinical Associate Professor of Thoracic and Cardiovascular Surgery, University of Miami School of Medicine, Miami

David C. Sabiston, M.D.

Adjournment

SECTION ON RADIOLOGY
SECTION I
(Co-sponsored by Florida Radiological Society)

Friday—2:00 p.m. to 4:30 p.m.

Robert J. Mandel, M.D., Melbourne
Program Chairman

Welcome and Opening Remarks—Paul J. Popovich, M.D., President, Florida Radiological Society, Melbourne

"The Physics of CAT Scanning," Jerome Sheldon, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, and Attending Radiologist, Mt. Sinai Hospital, Miami Beach

"CAT Equipment," O. Frank Agee, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville; and Juri Kaude, M.D., Professor of Radiology, University of Florida College of Medicine, Gainesville

"The Health System Agency and Radiology," Kim Beaton, Chairman, Regional Health System Agency, Orlando; and Jerry Conger, Office of Medical Services, Tallahassee

Adjournment

SECTION ON RADIOTHERAPY
SECTION I
(Co-sponsored by Florida Radiological Society)

Friday—2:00 p.m. to 4:30 p.m.

Robert J. Mandel, M.D., Melbourne
Program Chairman

Program to be Announced

SECTION ON PATHOLOGY
(Co-sponsored by Florida Society of Pathologists)
Friday—4:00 p.m. to 5:00 p.m.

Morton J. Robinson, M.D., Miami Beach
Program Chairman

"Contributions of Pathology to the Understanding of Leukemia," Louis B. Thomas, M.D., Chief, Laboratory of Pathology, National Cancer Institute, Bethesda, Md.

Adjournment

SECTION ON INTERNATIONAL COLLEGE OF SURGEONS
(Co-sponsored by Florida State Surgical Division, International College of Surgeons)

Friday—4:00 p.m. to 5:00 p.m.

Julian A. Rickles, M.D., Miami Beach
Program Chairman

"Clinical Use of Sympathetic Nerve Block," Julian A. Rickles, M.D., Acting Chief of General Surgery, Mt. Sinai Medical Center, Miami Beach

Questions and Answers

Adjournment

SATURDAY MORNING—MAY 7

SECTION ON RADIOLOGY
SECTION II
(Co-sponsored by Florida Radiological Society)

Saturday—8:00 a.m. to 11:10 a.m.

Robert J. Mandel, M.D., Melbourne
Program Chairman

"Update: CAT Scanning of the Head," Fredie P. Gargano, M.D., Clinical Professor of Radiology, University of Miami School of Medicine, and Chief and Attending Radiologist, Palmetto General Hospital, Miami

"Update: CAT Scanning of the Body," Jerome J. Sheldon, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, and Attending Radiologist, Mt. Sinai Hospital, Miami Beach

Break

"Nuclear Medicine and CAT Scanning: Competition and Teamwork," William M. Smoak III, M.D., Associate Professor, Division of Nuclear Medicine, University of Miami School of Medicine, and Attending Radiologist, Mt. Sinai Hospital, Miami Beach

Adjournment

SECTION ON ANESTHESIOLOGY
(Co-sponsored by Florida Society of Anesthesiologists)

Saturday—Time to be Announced

Alfred Feingold, M.D., Miami
Program Chairman

Program to be Announced

SECTION ON OBSTETRICS AND GYNECOLOGY
(Co-sponsored by Florida Obstetric and Gynecological Society)

Saturday—Time to be Announced

John E. Startzman, M.D., Orlando
Program Chairman

Program to be Announced

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY
(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)

Saturday—Time to be Announced

Jack D. Norman, M.D., Miami
Program Chairman

Program to be Announced

SECTION ON DERMATOLOGY
(Co-sponsored by Florida Society of Dermatology)

Saturday—8:30 a.m. to 12:30 p.m.

Phillip Frost, M.D., Miami Beach
Program Chairman

Program to be Announced

SECTION ON OPHTHALMOLOGY
(Co-sponsored by Florida Society of Ophthalmology)

Saturday—8:30 a.m. to 12:30 p.m.

Nicholas H. Kalvin, M.D., Naples
Program Chairman

Program to be Announced

SECTION ON NEUROSURGERY
(Co-sponsored by Florida Neurosurgical Society)

Saturday—8:30 a.m. to 12:30 p.m.

Hubert Aronson, M.D., Miami
Program Chairman

Program to be Announced

SECTION ON PEDIATRIC CARDIOLOGY
(Co-sponsored by Florida Association of Pediatric Cardiologists)

Saturday—8:30 a.m. to 11:30 a.m.

David G. Ruschhaupt, M.D., Jacksonville
Program Chairman

"Effect of Physical Training on Cardiac Function in Children," Elworth R. Buzkirk, Ph.D., Human Performance Research Laboratory, Pennsylvania State University, University Park, Pa.

Coffee Break

"Non-Invasive Evaluation in Transposition of the Great Arteries," Pedro L. Ferrer, M.D., University of Miami Hospitals and Clinics, and Assistant Professor of Pediatrics

"Vectorcardiographic Evaluation of Rheumatic Fever," Benjamin Victorica, M.D., Associate Professor of Pediatrics, University of Florida College of Medicine, Gainesville

"Septal Hypertrophy in Children," David G. Ruschhaupt, M.D., Division of Pediatric Cardiology, University Hospital, Jacksonville

"Cardiac Catheterization in a Community Hospital—1977 Update," Sidney Brodsky, M.D., Assistant Professor of Pediatrics, University of South Florida College of Medicine, Tampa

Adjournment

SECTION ON SURGERY
(Co-sponored by Florida Chapter, American College of Surgeons, and Florida Association of General Surgeons)

Saturday—9:00 a.m. to 12:00 noon

John C. Fletcher, M.D., Tampa
Program Chairman

Program to be Announced

SECTION ON ALLERGY
(Co-sponsored by Florida Allergy Society)

Saturday—8:30 a.m. to 12:30 p.m.

Roger J. Zwemer, M.D., Vero Beach
Program Chairman

"Theoretical Aspects of the Use of Methyl Xanthines In Bronchial Asthma," Andor Szentivanyi, M.D., Professor and Chairman, Department of Pharmacology, University of South Florida College of Medicine, Tampa

"Evaluation of Newer Drugs Used in Allergy Therapy," Elliot Ellis, M.D., Professor and Chairman, Department of Pediatrics, State University of New York at Buffalo School of Medicine, Buffalo, N.Y.

Speaker and Topic to be Announced

Questions and Answers

Adjournment

SECTION ON RADIOTHERAPY
SECTION II
(Co-sponsored by Florida Radiological Society)

Saturday—9:00 a.m. to 10:45 a.m.

Robert J. Mandel, M.D., Melbourne
Program Chairman

Selected Topics to be Announced

Adjournment

SECTION ON PEDIATRIC SURGERY
(Co-sponsored by Florida Association of Pediatric Surgeons)

Saturday—9:30 a.m. to 12:15 p.m.

Burton H. Harris, M.D., Jacksonville
Program Chairman

Welcome—James L. Talbert, M.D., President, Florida Association of Pediatric Surgeons, Gainesville

Introduction of Guest Speaker—Burton H. Harris, M.D., Program Chairman and Moderator, Jacksonville

"Esophageal Atresia and Tracheoesophageal Fistula," Thomas M. Holder, M.D., Professor of Pediatric Surgery, Children's Mercy Hospital and the University of Missouri School of Medicine, Kansas City, Mo., and President, American Pediatric Surgical Association.

Coffee Break

"Esophageal Strictures in Children," Farhat Moazam, M.D., Fellow in Pediatric Surgery, University of Florida College of Medicine (JHEP), Jacksonville; James L. Talbert, M.D., Professor and Chief of Pediatric Surgery, and Bradley M. Rodgers, M.D., Associate Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville

"Hidden Appendicitis in Cystic Fibrosis," William T. Brown, M.D., Chief of Surgery, Variety Children's Hospital, Miami; and Leonard Roudner, M.D., Chief Resident in Surgery, Mt. Sinai Hospital, Miami Beach

"Management of Intractable Ascites in Budd-Chiari Syndrome," Nasim Ahmed, M.D., Attending Pediatric Surgeon, All Children's Hospital, St. Petersburg.

"Prosthetic Porta-Systemic Shunts in Children," Farhat Moazam, M.D., Fellow in Pediatric Surgery, H. Warner Webb, M.D., Clinical Assistant Professor of Pediatric Surgery, Albert H. Wilkinson, Jr., M.D., Clinical Associate Professor of Pediatric Surgery, and Burton H. Harris, M.D., Clinical Assistant Professor of Pediatric Surgery, University of Florida College of Medicine (JHEP), Jacksonville

"Diagnosis and Management of Neurologic Deficits in Patients with Neuroblastoma," Mark Rosenfeld, M.D., Resident in Surgery, James L. Talbert, M.D., Professor and Chief of Pediatric Surgery, and Bradley M. Rodgers, M.D., Associate Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville

Adjournment

SECTION ON PHYSICAL MEDICINE AND REHABILITATION
(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)

Saturday—10:00 a.m. to 12:00 noon

Charles J. Kurth, M.D., Orlando
Program Chairman

Program to be Announced

SATURDAY AFTERNOON—MAY 7

SECTION ON DERMATOLOGY
(Continued)
(Co-sponsored by Florida Society of Dermatology)

Saturday—1:00 p.m. to 2:45 p.m.

Phillip Frost, M.D., Miami
Program Chairman

Program to be Announced

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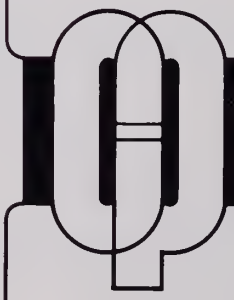
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Commentary

The following commentary by James Kilpatrick, published in The Florida Times Union, Jacksonville, August 23, is being published to clarify Dr. Thomas Brill's response on behalf of the Association.

Medical Crusade Moss Has Evidence But Little Help

James Kilpatrick

WASHINGTON — Why is Utah's Senator Frank Moss leading this fight? Why isn't the medical profession out in front instead? And why is the Justice Department lally-gagging on the job?

The questions come insistently to mind as one examines the dismaying record of ripoffs in the Medicaid and Medicare programs. Moss has been digging into these scandals for months. He has had mighty little help from any source.

Moss lays out evidence that cannot be brushed aside. A number of practicing physicians are little more than common thieves. They are swindlers, racketeers, con artists and plain crooks.

They are stealing money as surely as if they were engaged in bank robbery or embezzlement. And virtually nothing is being done about it.

THE SENATOR emphasizes repeatedly that the number of such contemptible characters is relatively small. Only 4 per cent of the nation's doctors are involved in fraud.

But in a profession as respected as the practice of medicine, 4 per cent should be a matter of acute concern. Obviously the situation concerns Senator Moss. If it acutely concerns the American Medical Association, the AMA's outrage somehow has escaped this correspondent.

Perhaps the AMA has made more than mere murmuring noises, but no crusade is taking shape.

Moss is the crusader. Through a Senate subcommittee, he has worked relentlessly to expose the crooked doctors. He has compiled volumes of hard evidence — damning evidence — of kickbacks on laboratory business.

Two weeks ago, he revealed the transcript of a conversation between two New York doctors, surreptitiously tape-recorded, in which one of them describes in lip-licking detail his technique for defrauding the Medicare program.

The techniques involve charges for patient visits that are never made, charges for lab work never done or never required, faked invoices and faulty memory.

Ripoffs from Medicaid, which serves welfare clients, are far worse than ripoffs from Medicare, which serves those on Social Security, but the differences are only differences in degree.

In a recent appearance before the Senate Finance Committee, Moss outlined half a dozen cases of typical Medicare fraud. The cases came from across the nation: New Jersey, Missouri, Texas, Colorado and California.

The cases involved a couple of osteopaths, a podiatrist, a surgeon, a dentist — all of them licensed practitioners. These were flagrant cases, involving the theft of thousands of dollars in public funds. Not one of the defendants served as much as a day in jail.

It is a great racket, this Medicaid/Medicare fraud. Looking at the Medicare program only, Moss notes that since 1969, Medicare's investigative unit has uncovered 20,000 apparent cases of possible fraud.

Of these, 459 have been referred to Justice for prosecution. Of the 459, only 210 actually have gone to trial. Of the 210 trials, 150 have resulted in conviction.

Of the 150 convicted defendants, three got two-year terms, two got one-year terms, and nine got sentences from 30 days to six months. The rest went effectively free, with no more than fines or probation.

THE ANSWER to this racket would appear to lie in revocation of a crooked doctor's license to practice. Such a procedure is more easily urged than fulfilled.

State licensing boards commonly are under-financed and under-staffed. No mechanisms exist that parallel the bar's mechanisms for disbarring a crooked lawyer.

The worst punishment a local medical society can impose is to deny the thieving doctor membership — and the crooks rarely are members anyhow.

The scandal has reached massive proportions. The Medicaid program is so shot through with fraud that Moss cannot hazard an estimate on the total ripoff.

His findings on Medicare are reasonably solid: About $1.5 billion of the $15 billion spent annually on Medicare is siphoned away by fraud.

Of that $1.5 billion, an estimated $300 million is stolen by physicians.

Surely thefts of this magnitude warrant the alarmed attention of both the medical profession and the Justice Department.

Reprinted from The Florida Times-Union, Jacksonville, August 23, 1976. (Copyright 1976, Washington Star Syndicate, Inc.)

Mr. James Kilpatrick, Columnist
c/o **Florida Times-Union**
1 Riverside Avenue
Jacksonville, Florida 32202

Dear Mr. Kilpatrick:

I have just read your column in today's Jacksonville **Times-Union** praising Senator Frank Moss for his efforts to expose Medicare and Medicaid fraud and castigating the AMA for lack of visible outrage. You flay the medical profession mercilessly, stating that a number of practicing physicians are "little more than common thieves. They are swindlers, racketeers, con-artist and plain crooks." Repeatedly in the column you referred to these people as "physicians" and referred to the group to which they belong as the "medical profession."

Your only reference to specific instances in your column are cases involving "a couple of osteopaths, a podiatrist, a surgeon, a dentist."

Certainly you are aware that the AMA is an organization of licensed M.D.s. There are no standard or regular osteopaths, podiatrists or dentists in the AMA. Of the five cases you referred to above, only one could conceivably be a member of the AMA, and since some osteopaths are surgeons even that is not entirely clear. I do not know, personally, the details of Medicare and Medicaid fraud, so I am not in a position to state to what extent M.D.s are involved in such fraud; I would be very surprised if there were not some so involved. But you have most unfairly treated the medical profession and the AMA in stamping us with culpability for the acts of people who are not M.D.s.

As a tax-paying citizen I certainly agree with you that any fraud involving tax funds must be stopped and the wrong-doers brought to justice. As a fellow citizen, I deplore with you the cruel siphoning away of money intended for the medical care of the poor and aging. And as a member of a state medical licensing board I know first-hand how right you are about the under-financed and under-staffed situation of so many state licensing boards.

In Florida I can assure you that the legislature has provided us with both the mechanism and authority for dealing with felonious physicians, and our Board is prepared to act with the full force of the law against any Florida licensee guilty of such felonious activity.

I would only ask that you paint with a slightly finer brush when referring to the misdeeds of health professionals and put the blame where it belongs. Or, as we might say in the medical profession, please cut us with a scalpel rather than an ax.

Thomas M. Brill, M.D.
Member, Florida State
Board of Medical Examiners
Gainesville

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Albert L. Rhoton, Jr., M.D. . . . Professor and Chief of Neurological Surgery at the University of Florida College of Medicine, has been named President-Elect of the Congress of Neurological Surgeons.

The world's largest neurosurgical group chose Dr. Rhoton at its Annual Meeting in New Orleans, October 25-29.

Dr. Rhoton, Guest Editor for this special issue of **The Journal,** also was elected recently to the Executive Committees of the Southern Neurosurgical Society and the Society of Neurological Surgeons.

Roger T. Sherman, M.D., of Tampa . . . has been elected Vice President of the American Association for the Surgery of Trauma. He is Professor and Chairman of the Department of Surgery at the University of South Florida College of Medicine.

Dr. Sherman and other officers were elected at the Association's annual meeting at Colorado Springs, Colo., in September.

Jacquelyne A. Gallop, Ph.D. . . . has been appointed Assistant Secretary for Program Planning and Development, Florida Department of Health and Rehabilitative Services.

Dr. Gallop, whose doctorate is in social work, had been serving as Deputy Assistant Secretary. In the new post she succeeds James A. Alford, M.D.

Florida Endocrine Society . . . will have its Clinical Seminar and Case Presentation program on January 22 and 23, 1977 at Lake Buena Vista. Information may be obtained by contacting **George P. Heffner, M.D.,** Secretary, 4602 N. Federal Highway, Ft. Lauderdale 33308.

The Florida Association of General Surgeons . . . will conduct its interim meeting at the Boca Raton Hotel and Club, November 12-14. The meeting will include a three-hour scientific session on Saturday morning, November 13.

Information may be obtained from **Robert H. Hux, M.D.,** Secretary-Treasurer, P. O. Box 1428, Leesburg, Fla. 32748.

E. M. Papper, M.D. . . . Vice-President for Medical Affairs and Dean of the University of Miami School of Medicine, has been elected to the Board of Governors of the Hospital Corporation of America. He and five other new members of the Board were installed on October 29.

The Board is a panel of physicians who advise the HCA management on professional, medical and technical subjects.

The Jewett Chair of Orthopedic Surgery . . . has been established at the University of Florida College of Medicine with a gift from **Eugene L. Jewett, M.D.,** one of Florida's pioneer surgeons.

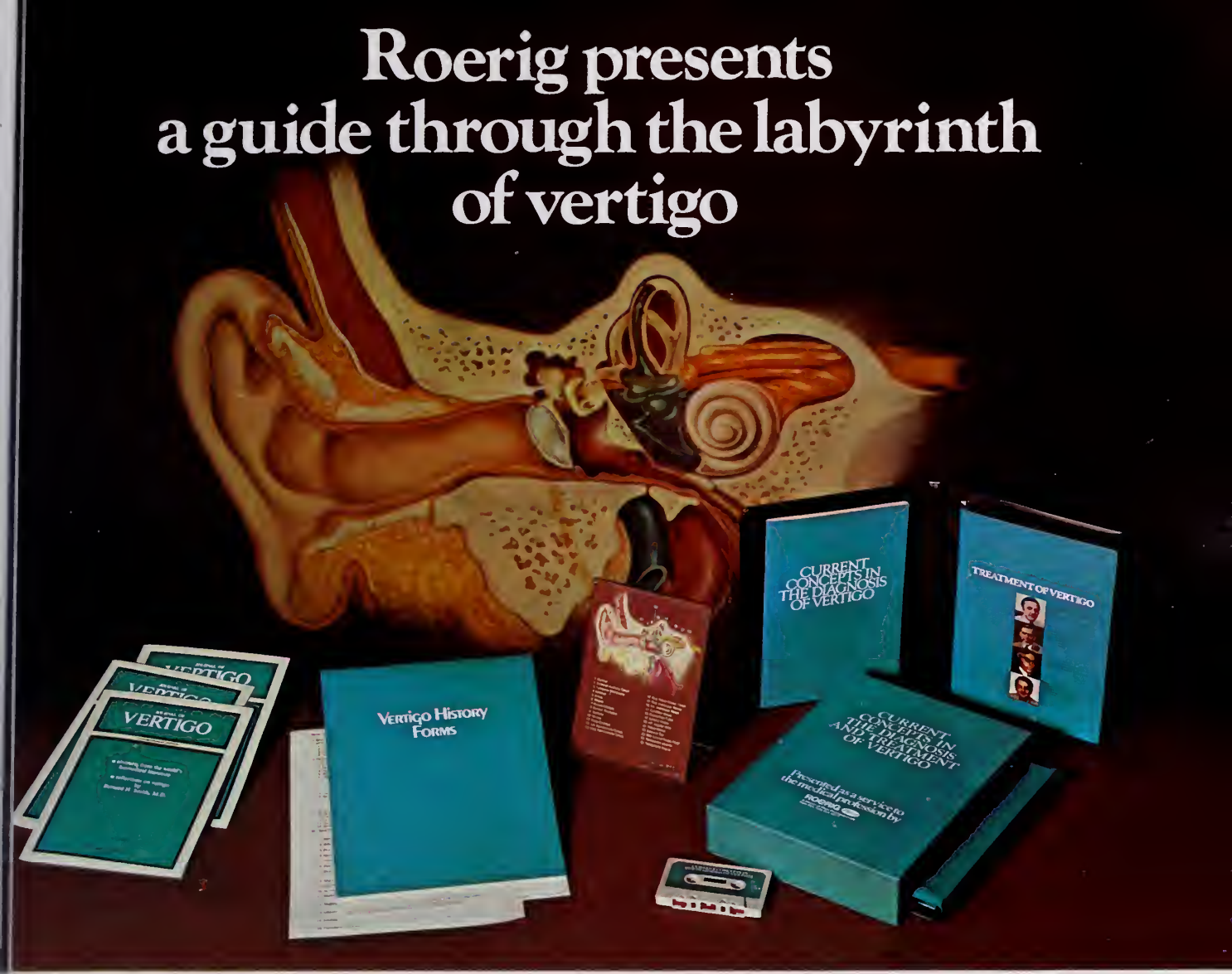
"Dr. Jewett's generous gift represents the first faculty chair to be established at the University of Florida by a single individual," according to Chandler A. Stetson, M.D., Dean of the College. A full professor of orthopedic surgery will be appointed to the Chair.

Dr. Jewett, of Winter Park, is living in retirement after nearly 40 years in the practice of orthopedics. His wife, Ruth Schwartz Jewett, M.D., also is retired from practice.

Robert J. Pollet, M.D. . . . Assistant Professor of Medicine at the University of South Florida has been awarded a grant of $9,915 from the Florida Affiliate of the American Diabetes Association.

The grant, reportedly the first made by the state group, will help support the second year of Dr. Pollet's project, "Characterization of the Insulin Receptor of the Human Lymphocyte." He hopes to isolate and describe how a receptor in the cell membrane surrounding the cell responds to the presence of insulin as the first step in insulin action, and to characterize the physical and chemical properties of this receptor.

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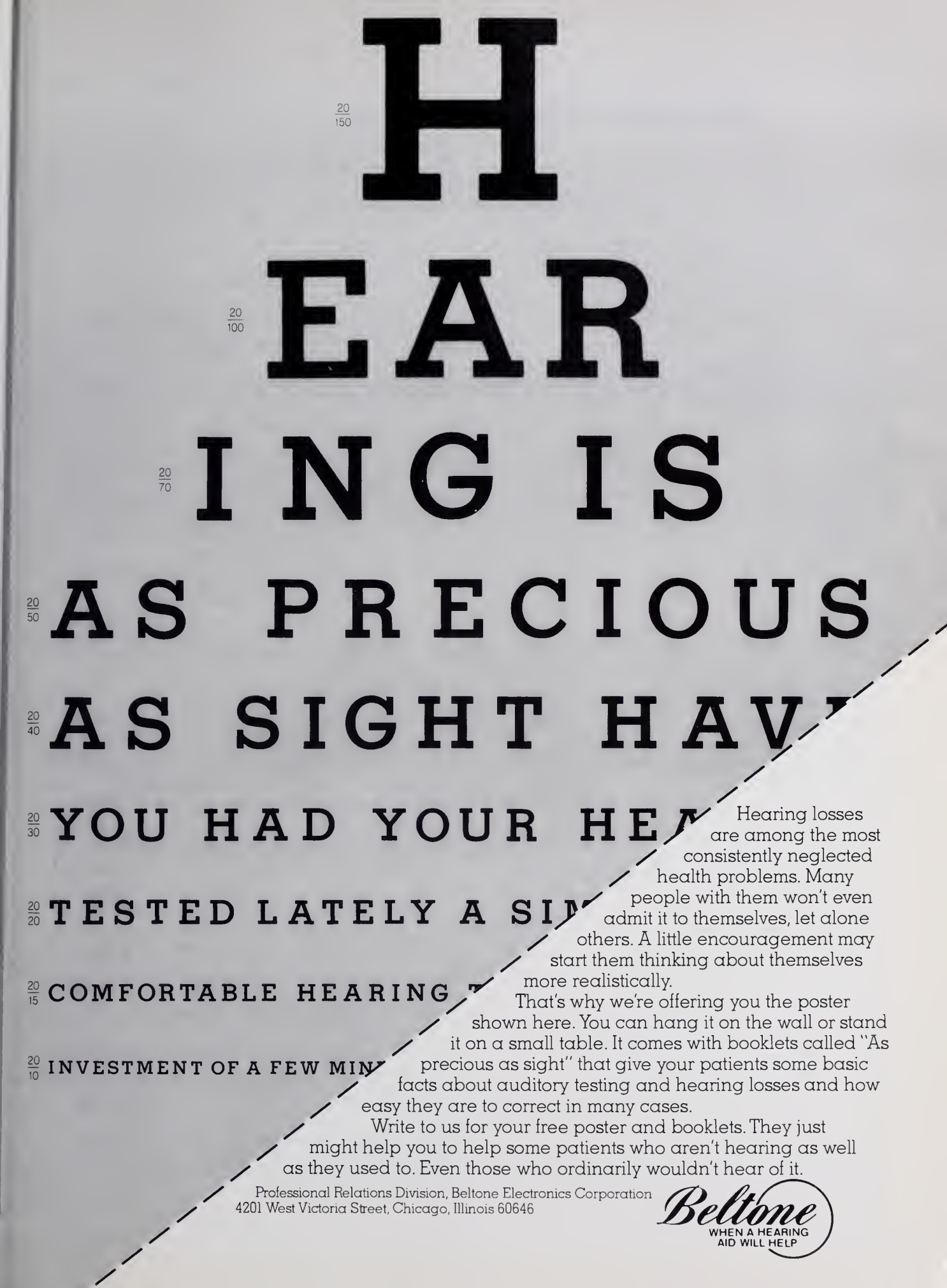
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Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

Genetic Screening Programs, Principles and Research by the Committee for the Study of Inborn Errors of Metabolism, Division of Medical Sciences. 388 Pages. Washington, D.C., National Academy of Sciences, 1975.

This book is a well presented report from the Committee for the Study of Inborn Errors of Metabolism. The authors state in their preface that "changes in disease patterns and a recent and rapid advance in genetics, indicate that screening for genetic characteristics will become more common in the future." Consequently, this study is an analysis of the current and future needs of genetic screening.

The study is directed not only to physicians, but, also to public health officials, lawyers, clergy, economists, educators, and social workers. As would be expected, considering the diversity of the reading audience, the material is presented in a nontechnical manner, dealing mostly with issues, programs, and opinions. There is little material on the mechanics of genetics, thus, genetic terminology is kept to a minimum and that which is used is defined in the glossary.

There are several chapters which cover such controversial issues as Legal Principles for Genetic Screening, Ethical Aspects of Genetic Screening, and An Economic Perspective on Evaluating Screening Programs. An excellent chapter is also included on the knowledge, attitude, and behavior of the physician and the general public. Each chapter is followed by a summary and list of references. There are numerous tables and appendices for reference and the book is adequately indexed.

Michael W. Popejoy
Orlando

Mr. Popejoy is a student at Florida Technology University working on a degree in Zoology and will continue for a Doctorate in Neurophysiology at the University of South Florida.

Current Concepts in Radiology, Vol. II, edited by E. James Potchen, M.D. 328 pages. Price $35.00. 354 illustrations. The C. V. Mosby Company, St. Louis, 1975.

The second volume of this series, like the first volume published in 1972, is designed "to bring together selected aspects considered important to the practicing radiologist for optimal application of current information to patient care."

The first four chapters described more effective uses of radiology with the chapter on management of the department providing a good summary of cost factors, personnel needs and space requirements of a Radiology Department. The other three chapters, however, provided little practical information and many pages of mathematical formulations were staggering.

Of the next three chapters concerning radiological imaging, the one on optimizing chest x-ray technique appeared helpful.

The last four chapters were more practical with special procedures in pulmonary radiology including needle biopsy, brush biopsy and tomography clearly presented.

I can only recommend limited portions of this compilation of articles.

Robert M. Hoffman, M.D.
St. Petersburg

Dr. Hoffman is a practicing Radiologist in St. Petersburg.

Help Your Doctor Help You by Walter C. Alvarez, M.D. 126 pages. Price 4.95. Celestial Arts, Millbrae, California, 1976. (paperback)

This small volume addressed to the patient is written by Dr. Alvarez in simple, understandable style similar to his newspaper column. A list of national organizations, such as the Arthritis Foundation, is included so that patients may write for specific information. A bibliography is included on other health related subjects. The price seems high.

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Food For People, Second Revised Edition, by Sarah R. Riedman. 228 Pages. Illustrated by Robert McGlynn. Introduction by Lord John Boyd Orr. Price $6.95. New York, Abelard-Schuman, 1976.

Solved: The Riddle of Heart Attacks by Broda O. Barnes, M.D., Ph.D. and Charlotte W. Barnes, A.M. 84 Pages. Price $2.50. Fort Collins, Colorado, Robinson Press, Inc., 1976.

Review of Medical Pharmacology, 5th Edition by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D. and Alan Goldfien, M.D. 740 Pages. Illustrated. Price $12.50. Los Altos, California, Lange Medical Publications, 1976.

General Urology, 8th Edition by Donald R. Smith, M.D. 492 Pages. Illustrated. Price $10.50. Los Altos, California, Lange Medical Publications, 1975.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

Contact Lenses and Corneal Disease by Antonio R. Gasset, M.D. 403 Pages. Illustrated. Price $22.50. New York, Appleton-Century-Crofts, 1976.

The Woman Alcoholic by Vera Lindbeck. 28 Pages. Price 35¢. New York, Public Affairs Pamphlets, 1975.

Principles of Clinical Electrocardiography, 9th Edition by Mervin J. Goldman, M.D. 412 Pages. Illustrated. Price $9.95. Los Altos, California, Lange Medical Publications, 1976.

Review of Medical Microbiology, 12th Edition, by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. 542 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price $15.00. Los Altos, California, Lange Medical Publications, 1976.

So Get On With It by Marilee Weisman & Jan Godfrey. 159 Pages. Illustrated. Price $8.95. Garden City, New York, Doubleday & Company, Inc., 1976.

Basic and Clinical Immunology edited by Hugh Fudenberg, M.D., Daniel P. Stites, M.D., Joseph L. Caldwell, M.D. and J. Vivian Wells, M.D. 653 Pages. Illustrated. Price $12.50. Los Altos, California, Lange Medical Publications, 1976.

Ganja in Jamaica, The Effects of Marijuana Use by Vera Rubin and Lambros Comitas. 240 Pages. Price $2.95. Garden City, New York, Anchor Press, 1976.

Diabetic Cooking Made Easy by Virginia M. Donahoe. 71 Pages. Illustrated. Price $3.95. Minneapolis, Minnesota, Burgess Publishing Company, 1973.

Sleep Disturbance and Hypnotic Drug Dependence edited by Anthony D. Clift, M.D. 352 Pages. Illustrated. Price $35.95. New York, Excerpta Medica/American Elsevier, 1975.

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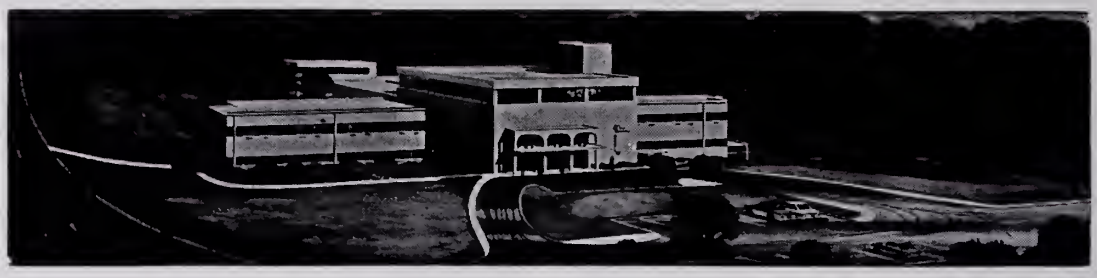
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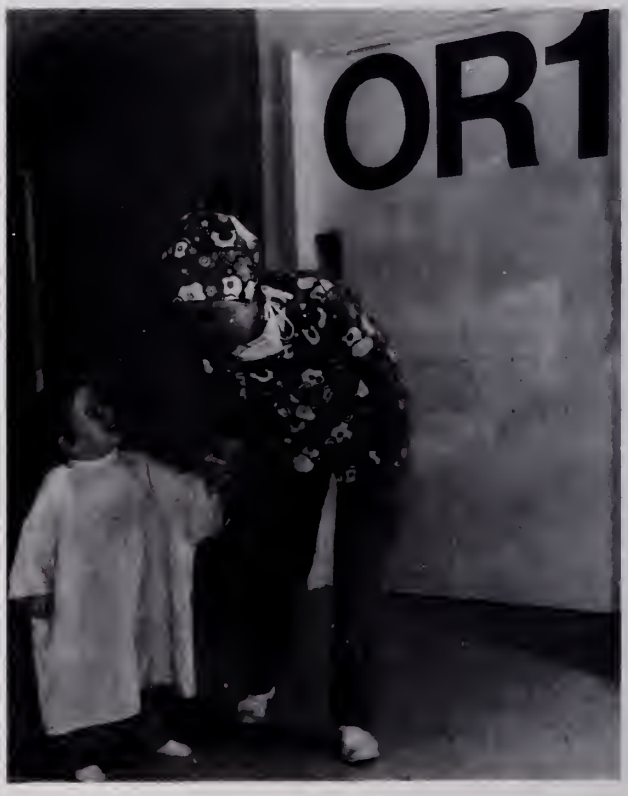
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Jan. 14-16 (Fri.-Sunday)

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Jan. 14-15 (Fri.-Saturday)

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Jan. 14-15 (Fri.-Saturday)

After "INTERNAL MEDICINE 1977"

"IMMUNOLOGY-INFECTIOUS DISEASES 1977"
Jan. 22-23 (Saturday-Sunday)

"ENDOCRINOLOGY 1977"
Jan. 22-23 (Saturday-Sunday)

"PULMONARY DISEASES 1977"
Jan. 22-23 (Saturday-Sunday)

"RHEUMATOLOGY 1977"
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SPEAKERS

INTERNAL MEDICINE
Ray W. Gifford, Jr. M.D.
Cleveland Clinic

NEUROLOGY
Herbert Karp, M.D.
Emory University
Clark H. Millikan, M.D.
Mayo Clinic
Robert G. Siekert, M.D.
Mayo Clinic
James Toole, M.D.
Bowman Gray School of Medicine

PEDIATRICS
Manuel Gomez, M.D.
Mayo Clinic

NEUROVASCULAR SURGERY
Robert G. Ojemann, M.D.
Massachusetts General Hospital
O. Howard Reichman, M.D.
Loyola Univ. Medical Center
James T. Robertson, M.D.
University of Tennessee
Jesse E. Thompson, M.D.
Baylor Univ. Med. Center
M. Gazi Yasargil, M.D.
Kantonsspital, Zurich, Switzerland

NEURORADIOLOGY
Juan M. Taveras, M.D.
Massachusetts General Hospital

PHYSICAL MEDICINE
Donald J. Erickson, M.D.
Mayo Clinic

NURSING
Dianne C. H. Bader, R.N.
Kantonsspital, Zurich, Switzerland
Kathleen Redelman, R.N.
Indiana University

PHYSICAL THERAPY
Martha Wroe, R.P.T.
University of Florida

SPEECH PATHOLOGY
Frederic L. Darley, Ph.D.
Mayo Clinic

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Physicians	$175.00
Nurses and Allied Health Professionals	$ 75.00
BROWARD COUNTY RESIDENTS	
Physicians	$ 75.00
Nurses and Allied Health Professionals	$ 35.00

FOR INFORMATION WRITE:
Mr. Ronald A. Nelson
Executive Director
American Heart Association
Broward County Chapter
440 North Andrews Avenue
Fort Lauderdale, Florida 33301

REGISTRATION CLOSES FEBRUARY 4, 1977.



pimco

PROFESSIONAL INSURANCE MANAGEMENT COMPANY
731 MAY STREET
P. O. BOX 40198
JACKSONVILLE, FLORIDA 32203
PHONE 364-5910
WATS 1-800-342-8349

fma-
pli-
trust

ADMINISTRATOR-FMA
INSURANCE PLANS

ADMINISTRATOR

The FMA Income Protection Plan

PIMCO, the Administrator of the Florida Medical Association's sponsored FMA-Professional Liability Insurance-Trust, takes pride in announcing its Risk Management Consultation Service, available to all medical hospitals and nursing homes. Because of its unique involvement with the FMA-PLI-Trust, PIMCO is genuinely concerned with the prevention of LOSS DOLLARS. The FMA-PLI-Trust membership is composed of a large majority of those physicians in Florida who currently have professional liability insurance. We possess statistical information covering the past 13½ years of liability insurance coverage IN FLORIDA—its gains and its losses.

The Risk Management Consultation Service offered by PIMCO will be claims oriented and not just another engineering experience. We have analyzed and distilled all of the previous PLI losses to seven categories. We are confident that with close involvement with those hospitals wherein our members practice, we can reduce these losses through an innovative loss prevention program. Remembering that 80 percent of malpractice litigation arises from a hospital experience, we see the need for closer involvement in this area. With our close affiliation with the 44 component medical societies of the Florida Medical Association, Inc., we intend to decrease loss dollars both within and without the hospital setting.

PIMCO has assembled an expert Risk Management Staff and with the help of a consultant from the Department of Risk Management and Insurance of the College of Business at Florida State University, has developed a comprehensive program which should decrease loss dollars. We will work closely with the hospitals and other institutions in implementing the recently enacted Risk Management Legislation and its Medical Incident Committees.

The FMA-PLI-Trust and the PIMCO staff are dedicated to finding a working solution to the professional liability insurance problem. The staff, while thoroughly familiar with the principles of the traditional malpractice insurance company, the Legislative process, medicine, and law, is aggressively exploring new and innovative approaches toward finding an equitable solution. We feel that Florida has a unique opportunity to lead the nation in this undertaking.

For further information concerning the Plan, contact
The Professional Insurance Management Company (PIMCO)

MEETINGS

Approved by FMA Committee on Continuing Medical Education

1976

NOVEMBER

Program for Foreign Medical Graduates, Nov. 1 & Jan. 22, Miami*

Computed Tomography of Body and Head—Current Concepts, Nov. 1-5, Tampa.+

Pigskin Review in Obstetrics and Gynecology, Nov. 5-6, Hertz Skycenter Inn, Jacksonville.**

Sixth George Papanicolaou Memorial Seminar, Nov. 10, The Rivergate, New Orleans, Louisiana. For information: George Ioannides, M.D., St. Francis Hospital, Miami Beach 33141.

Interdisciplinary Seminar, Nov. 11-12, South Building Auditorium, Cedars of Lebanon Health Care Center, Miami. For information: N. Joel Ehrenkranz, M.D., 1400 Northwest 12th Avenue, Miami 33136.

Hepatobiliary Disease in Clinical Practice, Nov. 11-13, Miami*

Clinical Application of Intra-Aortic Balloon Pump, Nov. 11-13, Miami*

Fall Meeting, Florida Society of Otolaryngology, Nov. 11-14, Sandpiper Bay, Port St. Lucie. For information: R.A. Bagby, M.D., 503 DeLeon, Tampa 33606.

Interim Meeting, Florida Association of General Surgeons, Nov. 12-14, Boca Raton Hotel and Club, Boca Raton. For information: Robert H. Hux, M.D., P.O. Box 1428, Leesburg 32748

The Cytologic Void: Urine Cytology, Nov. 13, Lakeland General Hospital, Lakeland. For information: James L. Holiman, M.D., 1417 Lakeland Hills Boulevard, Lakeland 33801.

Pediatric and Adolescent Echocardiography Course—Update '76, Nov. 13-14, Deauville Hotel, Miami Beach. For information: Stanley J. Goldbert, M.D., Univ. of Arizona, Arizona Medical Center, Tucson, Arizona 85724.

Pacemakers Updated, Nov. 13-14, Deauville Hotel, Miami Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg 33705

Initial Management of the Pediatric Emergency, Nov. 17-21, Caesars Palace, Las Vegas, Nevada. For information: J. Clifford Findeiss, M.D., 3900 Northwest 79th Avenue, Suite 469, Miami 33166.

Mease Hospital Tumor Board, Nov. 18, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Legal and Medical Aspects of Human Sexuality, Nov. 18-20, Miami*

Facial Anomalies Symposium, Nov. 18-19, Tampa.+

Third Workshop in the Use of Staplers in Surgery, Nov. 19-20, Wolfson Auditorium, Mount Sinai, Miami Beach. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Pediatric Emergencies—Little People, Big Problems, Nov. 21-24, Hyatt House, Orlando. For information: Registrar, Pediatric Emergencies, 1919 Beachway Road, Suite 5C, Jacksonville 32207.

Anesthesia Management for the Surgical Patient, Nov. 29-Dec. 12, Miami*

Emergencies in Internal Medicine, Nov. 30-Dec. 4, Miami*

DECEMBER

Death and Dying: Education, Counseling, and Care, Dec. 1-3, Hyatt Hotel, Orlando. For information: Suzan Schafer, M.D., 807 Seagle Building, Gainesville 32601.

Emergencies in Internal Medicine: Diagnosis and Management, Dec. 1-4, Americana Hotel, Miami Beach*

Fall Meeting Florida Society of Ophthalmology, Dec. 2-5, Marco Island Hotel and Villas, Marco Island, Florida. For information: Susan Waits, Florida Society of Ophthalmology, 346 Barnett Bank Bldg., Tallahassee 32301.

Symposium on Pathology, Dec. 7, Watson Clinic, Lakeland. For information: Eugene T. Davidson, M.D., Watson Clinic, Lakeland 33802

Mease Hospital Tumor Board, Dec. 16, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

1977

JANUARY

Pediatric Nephrology Seminar IV, Jan. 3-6, Miami*

Neuro-Ophthalmology Seminar, Jan. 3-7, Miami*

Initial Management of the Pediatric Emergency, Jan. 5-9, Konover Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Midwinter Cruise—Symposium on Intensive Care, Jan. 6-15, Miami*

Family Practice Weekend, Jan. 8, Tampa.+

Miami Winter Symposia—Biochemistry, Jan. 10-14, Miami*

Human Disease Related to Food and Chemical Sensitivity, Jan. 12-15, Miami*

11th Annual Postgraduate Seminar in Surgery, Jan. 12-15, Miami*

Hematology and Oncology 1977, Jan. 13-16, Miami*

Nephrology 1977, Jan. 14-15, Miami*

Pulmonary Disease 1977, Jan. 14-15, Miami*

Arthritis 1977, Jan. 14-16, Miami*

Gastroenterology and Hepatology 1977, Jan. 14-16, Miami*

Internal Medicine 1977, Jan. 15-21, Miami*

Second Review and Practical Advances in Pathology, Jan. 16-21, Miami*

Fourth Annual Postgraduate Seminar in Pediatric Neurology, Jan. 17-21, Konover Hotel, Miami Beach*

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Southeastern Breast Oncology Conference, Jan. 17-21, Marriott Hotel, Miami. For information: Oswald H. Coury, M.D., 7211 Southwest 62nd Ave., South Miami 33143.

Mease Hospital Tumor Board, Jan. 20, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

9th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-22, Carillon Hotel, Miami Beach. For information: Charles Lynne, M.D., 1200 N.W. 10th Avenue, Miami 33136

19th Annual Cardiovascular Seminar, Jan. 21-22, Tampa.+

Infectious Disease—Immunology 1977, Jan. 22-23, Miami*

Endocrinology 1977, Jan. 22-23, Miami*

Basic Sciences for the Practicing Physician: Biochemistry, Jan. 22-23, Miami*

Cardiology 1977, Jan. 24-26, Miami*

4th Annual Postgraduate Course in Practical Modern Neurology, Jan. 24-27, Miami*

Emergency Cardiac Care—1977, Jan. 27-30, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Florida Midwinter Seminar on Ophthalmology, Jan. 30-Feb. 2, Miami*

First International Glaucoma Congress, Jan. 31-Feb. 1, Diplomat Hotel, Hollywood. For information: John Bellows, M.D., 6 North Michigan Avenue, Chicago, Illinois 60602.

FEBRUARY

Update on Cancers of the Gastrointestinal System, Feb. 3-5, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Florida Midwinter Seminar on Otolaryngology, Feb. 3-5, Miami*

What's New in Neurosurgery for the General Practitioner, Feb. 4-5, Gainesville Hilton, Gainesville.**

Fred J. Wood Lecture Series III, Pediatrics and Adult G.U. Cancers, Feb. 4-5, Tampa.+

22nd Central Florida Medical Meeting, Feb. 4-6, Contemporary Resort, Lake Buena Vista. For information: Axel W. Anderson III, M.D., Suite 403, 85 West Miller Avenue, Orlando 32806.

3rd Annual Vail Conference in Anesthesiology, Feb. 5-12, Miami*

Thrombosis: Diagnosis, Prevention & Treatment, Feb. 7-9, Sonesta Beach Hotel, Key Biscayne. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Second Annual Seminar, Problems in Pediatric Radiology, Feb. 8-12, Dutch Inn, Lake Buena Vista.*

Symposium on Stroke—Moderns Trends In Cerebrovascular Disease, Feb. 9-12, Diplomat Hotel, Hollywood. For information: Mr. Ronald A. Nelson, Executor Director, Heart Association of Broward County, 440 N. Andrews Ave., Fort Lauderdale 33301

Midwinter Seminar in Ob/Gyn, Feb. 10-12, Tampa.+

Winter Management (Anesthesiology), Feb. 12-19, Miami*

Mease Hospital Tumor Board, Feb. 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Pediatric Dermatology Seminar, Feb. 24, Konover Hotel, Miami Beach. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Avenue, N. Miami Beach 33169.

Recent Advances in Cardiopulmonary Care III, Feb. 25-26, Holiday Inn, Lido Beach, Sarasota. For information: Robert E. Windom, M.D., 1901 Arlington Street, Sarasota 33579.

Basic Neurology for Psychiatrists, Feb. 28-Mar. 4, Miami*

MARCH

Third Annual Pediatric Surgical Postgraduate Course, Mar. 3-5, Americana Hotel, Miami Beach. For information: William T. Brown, M.D., Chief, Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155.

Postgraduate Seminar in Dermatology, Mar. 4-6, Miami*

Skin 1977: What Every Nurse Should Know, Mar. 4-6, Miami*

Pediatric Anesthesia Seminar—Spring Cruise, Mar. 5-15, Miami*

3rd Annual USF Cancer "Tumors of the Genitourinary Tract," March 5, Tampa.+

Annual Suncoast Trauma Seminar, March 9-11, Tampa.+

A Symposium in Gynecologic Endocrinology and Infertility, March 10-12, Hyatt House, Orlando. For information: B. Cantor, M.D., P.O. Box 13284, University Sta., Gainesville 32604

Basic Medical Hypnosis, Mar. 13-19, Miami*

Tenth Anniversary JHEP Instructional Course on Surgery of the Hand, March 16-20, Amelia Island. For information: Ira M. Dushoff, M.D., 580 W. 8th St., Jacksonville 32209.

Neurology for Non-Neurologist V: Movement Disorders, March 17, Tampa.+

Mease Hospital Tumor Board, March 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Seventh Annual Special Radiological Procedures Seminar, Mar. 19-22, Konover Hotel, Miami Beach.*

Fifteenth Annual Clinical Radiology Seminar, Advances in Cancer Diagnosis, Mar. 22-26, Konover Hotel, Miami Beach.*

9th Teaching Conference in Clinical Cardiology, Mar. 23-26, Sheraton-Four Ambassadors Hotel, Miami.*

Cardiology, March 25-27, Contemporary Hotel, Lake Buena Vista. For information: Jonathan O. Partain, M.D., 1131 South Orange Avenue, Orlando 32806.

Post-Conventional Seminar, Pathologic-Radiologic Correlations, Mar. 26-29, Caribbean Cruise.*

2nd Annual Vail Conference in Respiratory Therapy, Mar. 26-Apr. 2, Miami*

Pulmonary Infection, Pulmonary Infarction (Embolus), March 27-28, Tampa.+

Hepatitis: Diagnosis and Management, March 31, Tampa.+

APRIL

Postgraduate Seminar on Arthritis & Related Diseases, April 21-23, Hilton Hotel, Jacksonville. For information: Louis M. Sales, M.D., 2522 Oak Street, Jacksonville 32205.

Mease Hospital Tumor Board, April 21, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

MAY

Master Approach to Cardiovascular Problems, May 5-7, Miami*

Mease Hospital Tumor Board, May 19, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

U.S. POSTAL SERVICE

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Required by 39 U.S.C. 3685)

1. TITLE OF PUBLICATION	2. DATE OF FILING
The Journal of the Florida Medical Association, Inc.	Sept. 17, 1976

3. FREQUENCY OF ISSUE	A. NO. OF ISSUES PUBLISHED ANNUALLY	B. ANNUAL SUBSCRIPTION PRICE
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4. LOCATION OF KNOWN OFFICE OF PUBLICATION *(Street, City, County, State and ZIP Code) (Not printers)*
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5. LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS *(Not printers)*
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6. NAMES AND COMPLETE ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR

PUBLISHER *(Name and Address)*
Florida Medical Association, Inc.

EDITOR *(Name and Address)*
Gerold L. Schiebler, M.D., 735 Riverside Avenue, Jacksonville, Florida

MANAGING EDITOR *(Name and Address)*
Louise Rader, 735 Riverside Avenue, Jacksonville, Florida

7. OWNER *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.)*

NAME	ADDRESS
Florida Medical Association, Inc.	735 Riverside Ave.,Jacksonville,Fla.

8. KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES *(If there are none, so state)*

NAME	ADDRESS
None	

9. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES *(Section 132.122, PSM)*
The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes *(Check one)*

[X] HAVE NOT CHANGED DURING PRECEDING 12 MONTHS
[] HAVE CHANGED DURING PRECEDING 12 MONTHS *(If changed, publisher must submit explanation of change with this statement.)*

10. EXTENT AND NATURE OF CIRCULATION	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NO. COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
A. TOTAL NO. COPIES PRINTED *(Net Press Run)*	11,307	11,525
B. PAID CIRCULATION 1. SALES THROUGH DEALERS AND CARRIERS, STREET VENDORS AND COUNTER SALES	10,485	10,760
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D. FREE DISTRIBUTION BY MAIL, CARRIER OR OTHER MEANS SAMPLES, COMPLIMENTARY, AND OTHER FREE COPIES	266	298
E. TOTAL DISTRIBUTION *(Sum of C and D)*	11,018	11,300
F. COPIES NOT DISTRIBUTED 1. OFFICE USE, LEFT OVER, UNACCOUNTED, SPOILED AFTER PRINTING	289	225
2. RETURNS FROM NEWS AGENTS	0	0
G. TOTAL *(Sum of E, F1 and 2—should equal net press run shown in A)*	11,307	11,525

11. I certify that the statements made by me above are correct and complete.

SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER
Louise Rader Managing Editor

12. FOR COMPLETION BY PUBLISHERS MAILING AT THE REGULAR RATES *(Section 132.121, Postal Service Manual)*

39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the phased postage rates presently authorized by 39 U. S. C. 3626.

SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER
Louise Rader Managing Editor

PS Form 3526 Apr. 1976 *(Page 1)* (See instructions on reverse)

Classified Ads

physicians wanted

FAMILY PRACTITIONERS

MIAMI, FLORIDA: G.P. — Seven man multispecialty, fee-for-service group is seeking a G.P. to join the group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

EXCELLENT OPPORTUNITY IN TAMPA, FLORIDA FOR FAMILY PRACTICE, INTERNAL MEDICINE AND GENERAL SURGERY to join group practice close to major hospital and medical center. Physicians income based on percentage of billings with guarantee and opportunity to participate in ownership of center. No investment required. For full details contact W. R. Wallace, Business Manager, Oaktree Medical Center, 1113 East Buffalo Avenue, Tampa, Florida 33633. Phone: (813) 247-5921 or 855-4064.

SPECIALISTS

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

MIAMI, FLORIDA AREA: Multispecialty group fee-for-service group seeking full or part time Orthopedic Surgeon to join group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

ORTHOPAEDIC SURGEON — FLORIDA PRACTICE. Board qualified or certified to join 2-man highly reputable orthopaedic practice in beautiful community. Send professional and personal critique to L. Cerino, M.D., 1800 North Federal Highway, Pompano Beach, Florida 33062. Phone: (305) 943-1922.

URGENTLY NEEDED NEUROSURGEON for a large medical community. Opportunity either solo or a joint-existing group. Telephone: (813) 688-8401. Please send curriculum vitae to C-759; P. O. Box 2411, Jacksonville, Florida 32203.

TWO OR THREE INTERNISTS NEEDED in Florida coastal town of 35,000 with drawing area of 50,000. Solo or group practice. Income $70,000-$90,000 depending on willingness to work. Contact: Ronald C. Erbs, M.D., 1625 South Washington Avenue, Titusville, Florida 32780. Phone: (305) 267-5965.

GROUP OF 15 BOARD CERTIFIED INTERNISTS, several subspecialty certified, seeks association of board eligible or certified Internist with subspecialty training in rheumatology, infectious diseases, or cardiology. Excellent remuneration. No investment necessary. Academic stimulus. Modern hospitals. Beautiful area. Write full credentials to C-744, P. O. Box 2411, Jacksonville, Florida 32203.

TWO ANESTHESIOLOGISTS NEEDED: Growing multispecialty group seeks affiliation with board certified or eligible anesthesiologists. Excellent opportunity to either join group or provide service to its staff and other physicians in the community. Beautiful northeast Florida coastal city with excellent hospitals and good school system. Write C-698, P.O. Box 2411, Jacksonville, Florida 32203.

URGENTLY NEEDED NEUROLOGIST for a large medical community. Opportunity either solo or a joint-existing group. Telephone: (813) 688-8401. Please send curriculum vitae to C-760, P.O. Box 2411, Jacksonville, Florida 32203.

NEEDED: GENERAL, THORACIC, VASCULAR SURGEON for a growing area. No prima donna—willing to work, associate, build practice—without million dollar guarantee. Contact: L. C. Taylor, M.D., 1145 Lakeland Hills Boulevard, Lakeland, Florida 33801 or call (813) 682-4913.

GENERAL INTERNIST, INTERNIST-CARDIOLOGIST, INTERNIST-RHEUMATOLOGY AND INTERNIST-PULMONARY DISEASE NEEDED for outstanding practice opportunities. Fifty physicians medical group affiliated with 312-bed hospital, located on Florida's Gulf Coast. Population doubling in five years. Advantages of group practice combined with prerogatives of solo practice. Fee for service arrangement with substantial drawing account first year. No investment required. For full details, contact D. M. Schroder, Mease Hospital and Clinic, Dunedin, Florida 33528. Phone: (813) 734-6365.

GENERAL AND THORACIC SURGEON, ORTHOPEDIC SURGEON, INTERNIST, GENERAL PRACTITIONER, AND MEDICAL OPHTHALMOLOGIST WANTED for multispecialty group in central Florida on the Gulf coast. Guaranteed salary plus percentage. Busy physicians need associates. Reply with curriculum vitae to C-754, P.O. Box 2411, Jacksonville, Florida 32203.

PSYCHIATRIST: Immediate opening, full-time, to provide medical coverage in a community mental health center. Florida license required. Salary: $35,000 plus fringe benefits and malpractice insurance provided. Contact: William C. Young, Ed.D., Director, Marion-Citrus Mental Health Centers, 1206 E. Silver Springs Boulevard, Ocala, Florida 32670. Phone: (904) 629-8893.

FLORIDA — 36 year old F.A.C.O.G. in rural, rapidly growing central Florida county desires board certified/eligible OB-GYN associate. Send curriculum vitae to C-761, P.O. Box 2411, Jacksonville, Florida 32203.

MISCELLANEOUS

ADDITIONAL PHYSICIANS URGENTLY NEEDED in rapidly growing Gulf Coast area. Most needed are internists, ENT's and pediatricians. Excellent private practice opportunity. Rural. Drawing area 40,000. 200-bed excellently equipped hospital. Excellent schools. One and one half hours from medical schools and metropolitan areas. Office space available. Send curriculum vitae to C-708, P.O. Box 2411, Jacksonville, Florida 32203.

LAMINAR FLOW OPERATING ROOMS tested for conformation to Federal Standard 209-B, also yearly recertification test performed. Contact: Jake Truslow Company, P.O. Box E-S, Venice, Florida 33595. Phone (813) 485-4617.

PSYCHIATRIST/G. P. PHYSICIAN — Openings are anticipated from time to time in well established Community Mental Health Center. Florida license required. This is a CMHC with four large programs: Drug Abuse, Alcohol Counseling Center, Child Development Center and General Mental Health Program. Pensacola offers beautiful beaches and excellent recreational opportunities. No state income tax. Letters of inquiry, with resume', should be forwarded to Morris L. Eaddy, Ph.D., Executive Director, Community Mental Health Center of Escambia County, Inc., 1201 West Hernandez Street, Pensacola, Florida 32501. An equal opportunity employer.

EMERGENCY PHYSICIANS: Continue to live at home; supplement your income while commuting to our nationwide locations. Scheduling flexible—weekends, weekly or monthly—part-time, locum tenens or full-time. Commuting allowance, paid malpractice and state license fees; excellent remuneration. Contact Drs. Cooper, Spurgeon or Greenberg toll free 1-800-325-3982 for details.

TAX DEDUCTIBLE VACATIONS FOR MEDICAL PROFESSIONALS. Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D. C. 20016.

PHYSICIAN AND SONOGRAPHER TRAINING PROGRAM. All aspects of Diagnostic Ultrasound will be covered including how to start and operate an Ultrasound Department. One month physician program with three months and one year sonographer programs for qualified persons. Special arrangements may be considered. Limited number of applicants accepted. For further information phone or write: J. J. Crittenden, M.D., Diagnostic Ultrasound Department, West Florida Hospital and Clinic, 8383 North Davis Highway, Pensacola, Florida 32504. Phone (904) 478-4460, Ext. 174.

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with five practitioners in solo practice. Major equipment provided. Rent $250.00 per month. Excellent laboratory and x-ray with income based on use. Bookkeeping system shared. Financial assistance available to the right party. Contact: T. C. Kenaston, Jr., M.D., Box 550, Cocoa, Florida 32922.

Situations Wanted

BOARD ELIGIBLE GENERAL SURGEON: 39, completing military service July 1977. Seeks dynamic group or partnership. All locations considered; prefers large towns. Speaks fluently Spanish-French. Write C-757, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST-ENDOCRINOLOGIST, Board-certified in both, seeks hospital-based solo or group practice in Florida. Florida license applied (FLEX). Write C-758, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST—with training in cardiology including echocardiography seeks full time hospital-based practice or group practice. Call (305) 868-3080 after 6 p.m. or write C-751, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST—SUBSPECIALTY CARDIOLOGY: well trained in noninvasive cardiology, expertise echocardiography, currently employed at university affiliated hospital in Miami; seeks full time position in hospital based practice or group practice. Call (305) 868-3080 after 6 p.m. or write C-751, P.O. Box 2411, Jacksonville, Florida 32203.

FOREIGN YOUNG BOARD ELIGIBLE OB-GYN, with full training in U.S.A. For solo or group practice, in any size community in Florida. Available January 1, 1977. Write C-762, P.O. Box 2411, Jacksonville, Florida 32203.

Practice Available

PRACTICE FOR SALE—FAMILY PRACTICE: Exceptional opportunity, unlimited potential with minimum effort or expense, essentially no weekend or evening work. Contact: L. C. Taylor, 1145 Lakeland Hills Boulevard, Lakeland, Florida 33801 or call (813) 682-4913.

INTERNAL MEDICAL PRACTICE in North Miami, Florida available for sale. Write C-746, P.O. Box 2411, Jacksonville, Florida 32203.

PRACTICE FOR SALE: OB-GYN for 7 years on suncoast. Take over lease and present equipment. Must be certified or qualified. Write C-756, P. O. Box 2411, Jacksonville, Florida 32203.

PRACTICE FOR SALE: General practice, established 20 years in Miami. Financial details available upon request. Potential for growth. Ideal residential area, excellent schools. Write C-764, P.O. Box 2411, Jacksonville 32203.

Equipment for Sale

TWO GOOD modern examining tables, in excellent shape. Three wall otoscope, ophthalmoscope units with all accessories, and other miscellaneous equipment and office supplies. Very reasonable. Reply to: C. E. Menendez, M.D., P.O. Box 2778, Winter Haven, Florida 33880.

GROSSAN NASAL IRRIGATOR. For safe sinus treatment. Exhibited AAFP, AMA, AAOO, etc. Nine articles, reprints available. Hydro Med. Inc., P.O. Box 91273, Los Angeles, California 90009. Phone: (213) 670-1789.

FOR SALE: ONE 15' BAHAMIAN SAILING DINGHY—fibreglass, teakwood fittings, sail and carrying trailer, $900; one Sajou's Encyclopedia of Medicine—a rare antique book collection; One Pelton Steam Autoclave; one Picker x-ray Unit, 300 ma, 125 pkv. 90/15 tilt table, fluoroscope, spot film device, floor to ceiling tube stand with electromagnetic locks, videx collimator, electronic bucky, 12/1 grid. Contact: Alex Trombly (813) 253-0481, 8:00 - 5:00.

FOR SALE: Radiographic equipment—250 MA-110KV Fisher generator, floor to ceiling tube stand, Dynamax 40 tube, Bucky flat table—good condition, $4,000. Call Dr. Jelaso (813) 446-6760, Clearwater.

Real Estate

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

ST. PETERSBURG: Pasadena Medical-Dental Building, 419 Pasadena Avenue South. New deluxe office building. Just minutes from Palms of Pasadena and St. Petersburg General Hospitals. Custom designed for your needs. For complete information call Gerald F. Dalrymple (813) 866-2474.

OFFICE TO SUBLET. Fort Lauderdale-Plantation area. Excellent location on major thoroughfare. Many extras. Available immediately. 1,345 sq. ft. Very reasonable rent (all utilities included). Phone (305) 584-8050.

HOLLYWOOD, FLORIDA—Fully furnished internist office, equipped with laboratory, x-ray, kitchen, library, large waiting room. Up to 2,000 sq. ft. available for medical or allied field, except pediatrics or psychiatry. Finances open. Write C-755, P. O. Box 2411, Jacksonville, Florida 32203.

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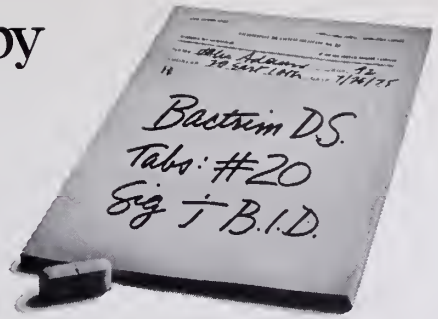
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1977 Florida Medical Association Annual Meeting, May 4-8, Americana Hotel, Miami Beach

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™
(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

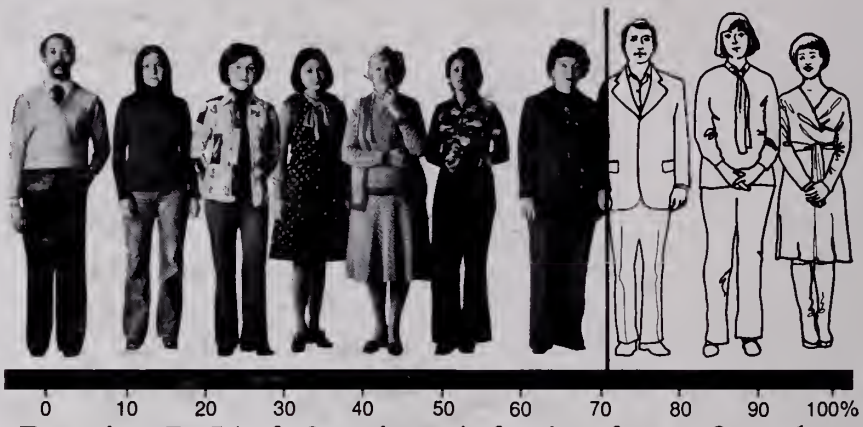
Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

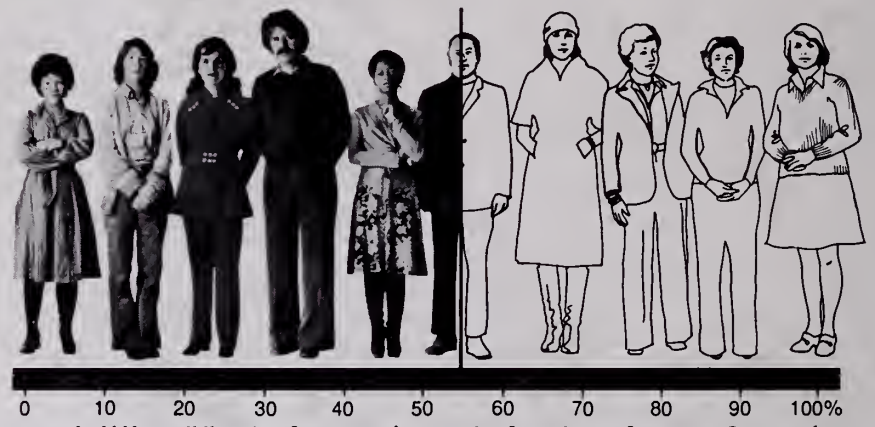
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In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

Double Strength tablets Just 1 tablet B.I.D.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

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May you live

May you flourish

like apple trees

like pear trees

in springtime

like wealthy autumn

of all things plentiful



Roumanian New Year Greeting

IMPORTANT FMA PLI INFORMATION — See Pages 1004, 1005 and 1012

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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This Issue

A Survey of Blood Pressure in 1,305 Normal Neonates
William Fanizzi, M.D., Kamal Taslimi, M.D. and Anthony Vasquez, M.D. 971
Evaluation of Hypertension
Michael J. Pickering, M.D. 975
Rhabdomyosarcoma of the Head and Neck in Children
John J. Rooks Jr., M.D. and Mutaz B. Habal, M.D. 980
Treadmill Exercise Testing in the Private Practice Setting—1976
Franz H. Stewart Jr., M.D. 984
Papular Urticaria
Robert H. Cohan, M.D. and Gary Griffin, M.D. 992

Special Article

Commencement Address—University of Florida College of Medicine—1976
A. Ashley Weech, M.D. 995

Sections

President's Page
Merry Christmas and A Happy New Year
JACK A. MACRIS, M.D. 953
Books Received 1019
Book Reviews 1018
Commentary
The National Health Crisis in Britain
JACK A. MACRIS, M.D. 954
Dean's Page
Carnegie Foundation: 1910 and 1976
CHANDLER A. STETSON, M.D. 958
Editorials
The Spectre At The Feast
FRANK G. SLAUGHTER, M.D. 1001
"Doctoring"
DON D. WEIFFENBACH, M.D. 1002
From the Editor's Desk 964
Letters to the Editor 1016
Medical News Around the State 1020
Organization
FMA Announces New Florida Physician's Insurance Reciprocal
W. HAROLD PARHAM, D.H.A. 1004
1977 Professional Liability Insurance Premiums
JAMES W. WALKER, M.D. 1005
Annual Meeting Scientific Program Approved for AMA Category I Credit 1007
Conference on the Identification of Needs and Standards for In-Hospital Critical Care 1010
FMA-PLI-Trust-PIMCO Announce New Risk Program for Florida Hospitals
JAMES W. WALKER, M.D. 1012
Others Are Saying
Doctors Who Play God
SIDNEY J. HARRIS 1023

Information

Classified Advertising 1035
FMA Officers and Council Chairmen 1038
Florida Organizations of Medical Interest 1034
Index to Advertisers 1038
Index to Volume 63 1028
Meetings 1026

DECEMBER COVER — Pen and ink holiday greeting by a friend of the Editor.



President's Page

MERRY CHRISTMAS
AND
A HAPPY NEW YEAR

Christmas is a time of emotional and spiritual reinforcement, which we can well use. Our mundane problems are set aside as we celebrate the birth of Christ. We rejoice in the spirit of PEACE ON EARTH, GOOD WILL TOWARD MEN.

As physicians caring for the sick, we have a special empathy toward those who are ill or injured in this season of joy. Their needs continue to occupy our hearts and our hands. Their suffering makes us even more acutely aware of our many blessings. We are grateful for our families, our good health, and the privilege of serving the people who come to us for help.

May the blessings of Christmas be with you all, now and through the coming year.

Jack A. MaCris, M.D.
President

See Commentary on Page 954

Commentary

The National Health Crisis in Britain

In October, Drs. Jere Annis, Vice Chairman of the Board, and Frank Holland, Vice President of the American Medical Association, invited Vern Astler as Immediate Past President of the FMA and me to attend an in-depth study of the National Health Service in Britain. The study was arranged for the AMA by a private British firm, Economic Models, Ltd. It included talks by physicians, bureaucrats, labor representatives, and members of Parliament, as well as visits to three hospitals in the London area. We dined with the President and Secretary of the British Medical Association. We had an opportunity to visit at length with these people, as well as nurses, social workers, and hospital employees.

On the plane home, Jere Annis wrote his impressions of the four days while they were still vivid and freshly in mind. His comments here express accurately what we all saw and felt.

"I saw a society that had lost its individualism, and had developed the complacent huddling together of individuals who have accepted a socialistic system in which only a few may achieve real success and eminence, and in which the goal of the others must be the equal distribution of mediocrity in service and care. The desire for excellence and superlative achievement is gone. The individual hopes only for fair, if limited, distribution of favors from government, and is contented with it. Medicine, too, has accepted this — the loss of resources, funds, salaries, and all the rest — and was content to deliver relatively unsophisticated services in grossly inadequate surroundings; witness the fact that England developed the EMI Scanner and to date has only four available in the whole country.

"Then, because of the economic crunch which really became alarming in 1974, an inflexible cap had to be placed on all expenditures. Funds for medical education, research and care, had to be curtailed. The funds were finite, as opposed to the infinitely expanding demand and need; yet, comprehensive care had been promised to all by law. This meant that since delivery of service could not generate any income in this socialistic setting, that any advancement or improvement of any one segment of the discipline of medicine must take place at the expense of some other, as long as any funds are involved.

"This has finally become apparent to Britain's physicians, and they are without exception alarmed, and almost in panic, about what the future holds for them and their patients. Furthermore, they are quite naturally divided against each other, like dogs scrambling for a few meatless bones. Their facilities are grossly inadequate by any American standards. They have no incentives for improvement in delivery of care, and really no opportunity.

"The basic philosophy of the system, ideal top-quality comprehensive medical care for everyone at the government's expense, was unsound and unachievable thirty years ago, and still is. It has bankrupt the system, raised taxes to a backbreaking level, and has failed to deliver universal, high-level care. Prolonged delay in all elective services has been the brake on expenditures, and has established priorities. New facilities are a token in number, and are second rate at best.

"The ever progressing thrust toward completely eliminating all private care (which seems to be a policy of the Labor Party), coupled with the divisive attacks upon the profession itself, must very shortly combine to destroy any high quality system of medical care, and result in a completely socialistic system in which there is an even distribution of mediocrity, and a total lack of excellence. With this will come the end of the fine legacy that British

medicine has given the world and the citizens of Britain.

"The British physicians fully realize this, but feel too far along the way to alter it. They are abject and depressed in a society that has physically eschewed personal responsibility and self-reliance, in favor of paternalistic governmental largess. It is the beginning of the end for individual British citizens and physicians.

"Ever since I left England I have been thinking of those fine unfortunate people—doctors and patients alike. Their faces are before me always—awake and asleep—and as I gazed into the sorrowful eyes of those who have wept for, but not really fought for, their personal integrity and freedom, I was engulfed by a smothering blanket of profound depression.

"As I looked longer, the faces began to blur and fuse—but after a bit the focus sharpened again and those faces, before British, began to look more and more like yours and mine—until finally I saw each of us clearly in the misty mirror before me. I shuddered and then slowly became aware of a chilling wind—a fearful, awesome, unearthly force, accelerating in thunderous, irresistible gusts that began sweeping all of us as shrinking, puny, political pawns into a huge all-consuming egalitarian sea of muddy mediocrity and deep despair—a dark ocean where all progress, growth, achievement and excellence must perish with us.

"I know that I must soon burst forth from this trance—hysterical and screaming. 'No, no, it can't happen here' . . . and it already will have."

Jack A. MaCris, M.D.
President

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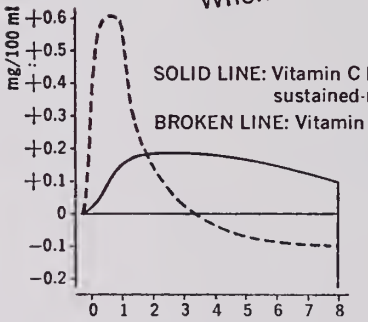


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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

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Dean's Page

Carnegie Foundation: 1910 and 1976

Chandler A. Stetson, M.D.

In 1910, Abraham Flexner made a report to the Carnegie Foundation for the Advancement of Teaching. This volume, entitled "Medical Education in the United States and Canada," stunned the American public and shocked those responsible for medical education into a reform movement which resulted in the closing of a large proportion of the nation's medical schools. Those which survived, together with a number of new schools established on the principles laid down by Flexner, have given us today a medical education system second to none in the world.

Over the years, the Carnegie Foundation for the Advancement of Teaching has continued to support a series of indepth studies of policy matters relating to higher education. The most recent report in this series, "Progress and Problems in Medical and Dental Education: Federal Support versus Federal Control," has just been published and contains some cogent and thought-provoking recommendations which, while perhaps less revolutionary than those of the Flexner report of 1910, nonetheless deserve our attention and support.

The report contains three explicit warnings: (1) that "we are in serious danger of developing too many new medical schools, and decisive steps need to be taken by both federal and state governments to stop this trend;" (2) that "there is a critical danger that concern over geographic maldistribution of health manpower and overspecialization in medicine will lead to excessive and unwieldy federal controls rather than to policies emphasizing incentives to effect the required changes;" and (3) that "the time has come to cease relying on foreign medical graduates to meet the need for physicians in the United States." While we have heard this kind of concern expressed before, especially in the last two or three years, there has not previously been such an authoritative and comprehensive analysis of these problems, with such sharply focused and well documented conclusions. Just as the Flexner report succeeded in focusing attention on what had for years been recognized as a problem area, so it seems likely that this current Carnegie report will serve to stimulate those responsible for state and federal health policies to undertake appropriate action in these problem areas.

The report is particularly timely and cogent in its treatment of the "number of physicians" issue. While it was a matter of national policy to encourage the creation of new medical schools and the expansion of existing ones during the 1960's, in an effort to remedy what was perceived as a shortage of physicians in the United States, there is now good reason to think that the expansion has gone far enough and, in fact, that the new medical schools being developed with Veterans Administration funding during the past two years may be in excess of our needs. "We seriously question whether they should be established. We also question whether the VA should have been given authority to provide funds for new medical schools . . .". The increase in the size of medical school entering classes has been far greater and has come about far faster than was expected. First-year enrollments rose slowly from about 6,000/year in 1930 to about 9,000/year in 1970, then jumped dramatically to over 16,000/year this year and are still climbing. Current administration estimates are that there will be 207-217 physicians per 100,000 population by 1985. Compared to the figure of 147/100,000 in 1976, this means about a 50% increase in the ratio—"very high in relation to previous American experience and also to current foreign experience." The report predicts that a surplus of physicians would result in a decline in average income and in average hours of work, "both of which have been exceedingly high."

Seen as contributing to the likelihood of an overall surplus is the current rapid expansion in the numbers of physician assistants and nurse practitioners. There are about 2,800 "physician extenders" now practicing in the United States and 5,700 more are expected to graduate by the end of 1977. While follow-up studies of these programs indicate that they are making an impressive contribution to overcoming shortages in rural areas, they are costly and have not made similar contributions to inner city shortages.

The thorough studies and documentation available in this report deserves careful study by our legislators and by all of us interested in the profession, either as educators or as practitioners. The Carnegie Foundation deserves our gratitude for this latest in a series of distinguished policy papers of which the Flexner report was the first.

Dr. Stetson, University of Florida College of Medicine, Gainesville 32601.

Dr. Stetson is Dean and Vice President for Health Affairs, University of Florida College of Medicine, Gainesville.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

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■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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DEPARTMENT OF MEDICINE

"INTERNAL MEDICINE ASSEMBLY 1977"

January 13-23, 1977

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Program Coordinator: Jose S. Bocles, M.D.

For each of the past eleven years, the Department of Internal Medicine of the University of Miami School of Medicine has conducted an annual course on recent advances in internal medicine. Because many internists also have a subspecialty, a new format is being initiated. In addition to the well-established five-day course, comprehensive subspecialty reviews lasting for one and one-half to four days will be presented before and after the main program as scheduled below. Guest and University of Miami faculty will present the most important aspects of the subspecialties with emphasis on current developments and their practical clinical applications.

Enrollment is possible in the main meeting, one or more subspecialty courses, or any combinations that the schedule permits.

Twelfth Annual Postgraduate Course

"INTERNAL MEDICINE 1977"

January 16-21, 1977

AND

Subspecialties Courses

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"CARDIOLOGY 1977"
Jan. 14-16 (Fri.-Sunday)

"GASTROENTEROLOGY-HEPATOLOGY 1977"
Jan. 14-16 (Fri.-Sunday)

"NEPHROLOGY 1977"
Jan. 14-15 (Fri.-Saturday)

"TOMORROW'S DIAGNOSES AND NEXT YEAR'S TREATMENT"
Jan. 14-15 (Fri.-Saturday)

After "INTERNAL MEDICINE 1977"

"IMMUNOLOGY-INFECTIOUS DISEASES 1977"
Jan. 22-23 (Saturday-Sunday)

"ENDOCRINOLOGY 1977"
Jan. 22-23 (Saturday-Sunday)

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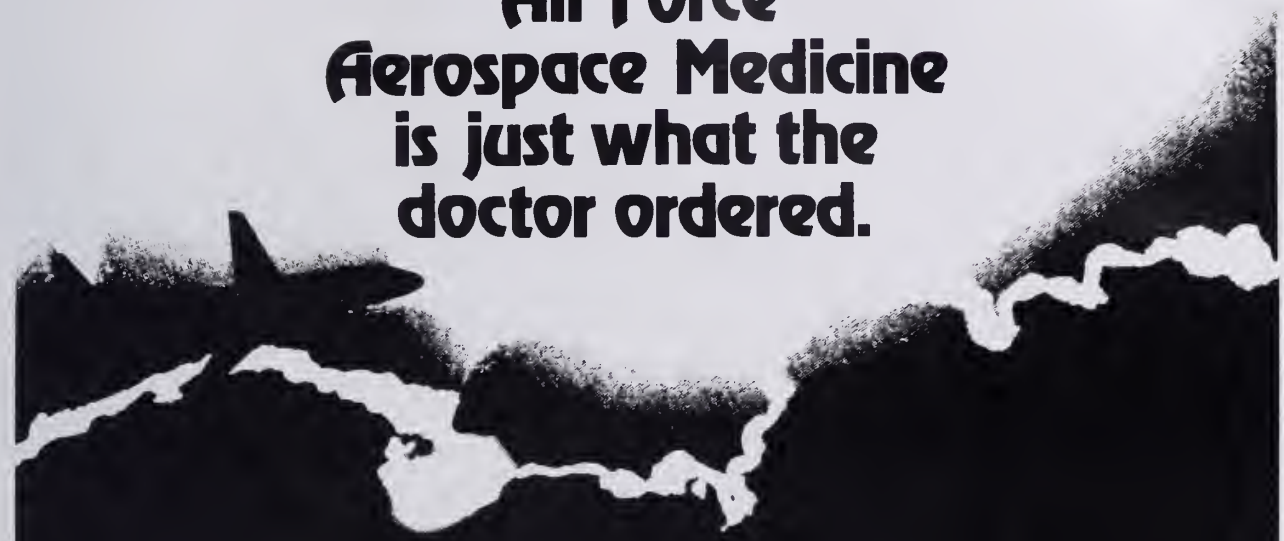
For information and application write to:

J. Bocles, M.D.
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University of Miami School of Medicine
P.O. Box 520875
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HOTEL: The Fontainebleau Hotel in Miami Beach has reserved a limited number of rooms, available from January 12 through January 23, 1977. Special rates are $43/Single and $47/Double.

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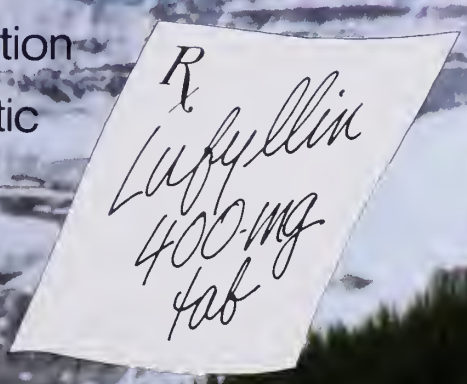
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Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: In individuals who have shown hypersensitivity to any of its components.

Dyphylline should not be administered concurrently with other xanthine preparations.

Precautions: Use with caution in patients with severe cardiac disease, hypertension, hyperthyroidism, or acute myocardial injury. Particular caution in dose administration must be exercised in patients with peptic ulcers, since the condition may be exacerbated. Chronic oral administration in high doses (500 to 1,000 mg) is usually associated with gastrointestinal irritation.

Great caution should be used in giving dyphylline to patients in congestive heart failure. Such patients have shown markedly prolonged blood level curves which have persisted for long periods following discontinuation of the drug.

Adverse Reactions: Note: Included in this listing which follows are a few adverse reactions which may not have been reported with this specific drug. However, pharmacological similarities among the xanthine drugs require that each of the reactions be considered when dyphylline is administered.

The most consistent adverse reactions are:

1. Gastrointestinal irritation, nausea, vomiting, and epigastric pain, generally preceded by headache, hematemesis, diarrhea.
2. Central nervous system stimulation: irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions, agitation.
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, marked hypotension, and circulatory failure.
4. Respiratory: tachypnea, respiratory arrest.
5. Renal: albuminuria, increased excretion of renal tubule and red blood cells.
6. Others: fever, dehydration.

Dosage and Administration: Adults—Usual Dose—15 mg/kg every 6 hours, up to four times a day. The dosage should be individualized by titration to the condition and response of the patient, with therapeutic blood levels considered to be between 10 mcg/ml and 20 mcg/ml. Levels above 20 mcg/ml may produce toxic effects.

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FROM THE EDITOR'S DESK

Alexander M. Schmidt, M.D., Commissioner of the Food and Drug Administration, left the federal post on November 30 to rejoin the University of Illinois Medical Center as Vice Chancellor for Health Sciences. Dr. Schmidt said his departure is not related to a current controversy in which the FDA stands accused of laxity in the supervision of new drug testing procedures. The General Accounting Office has charged that some researchers keep inaccurate records, do not inform patients they are subjects of experiments, and delegate responsibility to unqualified persons. Also, 34 FDA employees told a Senate Committee that the agency is biased toward the drug manufacturing industry.

* * * *

Complete intellectual honesty is a must for today's practicing physician, according to Max H. Parrott, M.D., Immediate Past President of the AMA. In a recently published essay, Dr. Parrott writes: "Sound thinking behind a diagnosis must be founded not only upon a solid base of scientific knowledge, but also upon true facts—facts tempered by judgment based upon experience." Dr. Parrott's comments appear in a new anthology entitled "The Ethical Basis of Economic Freedom," published by American Viewpoint, Inc.

* * * *

The government's Consumer Price Index shows that physicians' fees rose 0.8% in June, a slightly higher increase than those recorded for April and May. The all-items index rose 0.5%. For the first six months of the year, all items rose 2.3%, with the increase in physicians' fees quoted at 5.6%.

* * * *

Look for Physicians Assistants to become more active in preventive medicine programs. The American Association of Physicians Assistants announced in August it will begin promoting programs to use PAs in that role. First step in the program is the nationwide promulgation of stop-smoking clinics through AAPA members and their physicians. Such a program already is under way in St. Petersburg.

AMA has petitioned Congress to restore tax exemptions on federal government loan and scholarship programs for medical students. At the present time about 5,000 students in the Armed Forces Health Professions Scholarship program and another 2,700 in the National Health Service Corps scholarship program are required to pay taxes on those grants. According to AMA Executive Vice President James H. Sammons, M.D., continued taxation will act as a deterrent to acceptance of scholarships with a service commitment.

* * * *

AMA Trustees have approved a 1977 budget that calls for $46.2 million in spending. More than half of that was earmarked for scientific activities, including continuing medical education. AMA expects to take in $57.7 million and put about $11.5 million in reserve. Meanwhile, AMA membership at mid-summer stood at 162,432, which included 144,723 dues-paying members, 9,500 housestaffers and 8,209 students.

* * * *

In South Dakota, the State Supreme Court has sided with a hospital medical staff in a court bout with the hospital's board of directors. The Board of the St. John's Regional Medical Center maintained that its responsibility for quality of care gives it the authority to amend staff by-laws. It was the position of the medical staff that such action constitutes unlawful practice of medicine. The high court was unanimous in its ruling the hospital board does not have unilateral amendatory power.

* * * *

The Fifth Annual AMA Leadership Conference will be held in Chicago, January 20-23, 1977. The theme is "Portrait: Dynamic Leadership for '77." A seminar on "Assault on Professionalism" will provide a forum for discussion of current and widespread attacks on various professions.

The new year will bring another hike in Social Security taxes for many workers and self-employed persons. The taxable salary base will be increased to $16,500 from this year's $15,300. For employed persons, the tax rate will remain the same, with both employer and employee each paying in 5.85% apiece. Each will pay a maximum tax of $965.25 for the year. Self-employed persons will continue to contribute 7.9% for a maximum contribution of $1,303.50.

* * * *

The group practice system of dispensing health care has been growing in the 1970s, according to the AMA. The current edition of "Profile of Medical Practice," prepared by AMA's Center for Health Services Research and Development, shows that 66,842 physicians—23.5% of the active nonfederal physician population—work in 8,483 medical groups. The Center's studies indicate that the small-scale, single-specialty group of three to five physicians may well become the predominant choice of young physicians.

* * * *

The American Board of Plastic Surgery will become the sixth specialty board to implement a recertification program, beginning in 1977. Recertification procedures already are in effect for the boards of allergy and immunology, family practice, internal medicine, obstetrics and gynecology, and physical medicine and rehabilitation. The recertification plan was approved at the September meeting of the American Board of Medical Specialties, which also okayed a request by the Board of Pediatrics to offer special competency certification in endocrinology. The Board of Neurological Surgery advised ABMS it plans to change training requirements and lengthen the residency program to five years after a year of surgery.

* * * *

The Medical Relations Committee of the Health Insurance Association of America has endorsed the Fourth Edition of AMA's "Current Procedural Terminology." The Fourth Edition is to be published in early 1977.

* * * *

The United States market for medical imaging equipment is expected to triple within a decade, according to the Stanford Research Institute, Menio Park, Calif. Sales of x-ray, nuclear medicine, ultrasound with related equipment and supplies reached $1.2 billion last year; and it is expected to reach almost $3 billion by 1985. SRI cites heavy demand for computed tomographic (CT) and ultrasound scanners. Contributing to the demand for an increased number of CT scanners, SRI reports, are the profitable economics of such an operation, proven capabilities in diagnosing many types of pathology, medical prestige, and the threat of government regulation of future scanner purchases.

* * * *

Two new medical schools—Wright College of Medicine in Dayton, Ohio, and the University of Health Sciences of the Uniformed Services in Bethesda, Md.—enrolled their first classes this year. They bring to 116 the number of operational schools in this country. Nationally, medical school enrollment totals 57,236, including 15,349 first-year students. The first year enrollment is an increase of 24% over five years ago, and more than 9% over last year. One out of every five students in medical school this year is a woman.

* * * *

An orientation program will be conducted for medical students attending the AMA Clinical Convention in Philadelphia in December. At the meeting on December 4, students will be briefed on the operation of the House of Delegates and other AMA affairs.

* * * *

A poll of physicians has resulted in a statewide Professional Standards Review Organization in Kentucky. Physicians in Arizona, Indiana, Louisiana, North Carolina and Virginia also are being polled to determine if multiple areas will be consolidated into statewide PSROs.

The Editor

CIBA nationwide CHEC program reveals*

An estimated 13 million American hypertensives aren't getting their medicine.*[1]



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Once dosage of individual components is titrated to your patient's needs, Ser-Ap-Es can be a logical choice for long-term therapy.

Use Ser-Ap-Es cautiously in patients with advanced renal damage or cerebrovascular accident. Discontinue at first sign of mental depression.

*CHEC (Community Hypertension Evaluation Clinic), the program that screened 1,049,225 Americans for hypertension, showed that 55.1% of the hypertensives screened were previously undetected, untreated, or uncontrolled. The 13 million figure is a projection based on this percentage and the estimated 24 million hypertensives in the United States. CHEC was a two-year, nationwide study sponsored by CIBA and local health organizations.[1]

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reserpine 0.1 mg
hydralazine hydrochloride 25 mg
hydrochlorothiazide 15 mg

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WARNING
This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

INDICATIONS
Hypertension. (See box warning.)

CONTRAINDICATIONS
Reserpine: Known hypersensitivity; mental depression (especially with suicidal tendencies); active peptic ulcer; ulcerative colitis; electroconvulsive therapy.
Hydralazine: Hypersensitivity; coronary artery disease; mitral valvular rheumatic heart disease.
Hydrochlorothiazide: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS
Reserpine: Use with extreme caution in patients with a history of mental depression. Discontinue at first sign of despondency, early morning insomnia, loss of appetite, impotence, or self-deprecation. Drug-induced depression may persist for several months after drug withdrawal and may be severe enough to result in suicide.
MAO inhibitors should be avoided or used with extreme caution.
Hydralazine: Hydralazine may produce in a few patients a clinical picture simulating systemic lupus erythematosus. In such patients hydralazine should be discontinued unless the benefit to risk determination requires continued antihypertensive therapy with this drug. Symptoms and signs usually regress when the drug is discontinued but residua have been detected many years later. Long-term treatment with steroids may be necessary.
CBC's, L.E. cell preparations, and antinuclear antibody titer determinations are indicated before and periodically during prolonged therapy with hydralazine or if the patient develops any unexplained signs or symptoms.
A positive antinuclear antibody titer and/or positive L.E. cell reaction requires that the physician carefully weigh the implications of the test results against the benefits to be derived from antihypertensive therapy with hydralazine.
Use MAO inhibitors with caution.
Hydrochlorothiazide: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.
Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte imbalance may precipitate hepatic coma.
Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.
Sensitivity reactions are more likely to occur in patients with a history of allergy or bronchial asthma.
The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy
Reserpine: The safety of reserpine for use during pregnancy or lactation has not been established; therefore, the drug should be used in pregnant patients or women of childbearing potential only when, in the judgment of the physician, it is essential to the welfare of the patient. Increased respiratory tract secretions, nasal congestion, cyanosis, and anorexia may occur in neonates and breast-fed infants of reserpine-treated mothers since reserpine crosses the placental barrier and appears in maternal breast milk.
Hydralazine: Animal studies indicate that high doses of hydralazine are teratogenic in mice, possibly in rabbits, and not in rats. Although clinical experience does not include any positive evidence of adverse effects on the human fetus, hydralazine should be used during pregnancy only if the benefit clearly justifies the potential risk to the fetus.
Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.
Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS
Reserpine: Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or gallstones (biliary colic may be precipitated).
Exercise caution when treating hypertensives with renal insufficiency. Use cautiously with digitalis and quinidine.
Intraoperative hypotension has occurred in hypertensive patients receiving rauwolfia preparations, but withdrawal of reserpine does not assure that circulatory instability will not occur in such patients.
Hydralazine: Use cautiously in suspected coronary artery or other cardiovascular disease, cerebral vascular accidents, and advanced renal damage. Postural hypotension may occur, and the pressor response to epinephrine may be reduced.
Peripheral neuritis, evidenced by paresthesias, numbness, and tingling, has been observed. Published evidence suggests an antipyridoxine effect and addition of pyridoxine to the regimen if symptoms develop.
Blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis, and purpura, have been reported. If such abnormalities develop, discontinue therapy. Periodic blood counts are advised during prolonged therapy.
Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. Observe patients for clinical signs of fluid or electrolyte imbalance (hyponatremia, hypochloremic alkalosis, and hypokalemia). Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbance such as nausea or vomiting.
Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of steroids or ACTH.
Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (eg, increased ventricular irritability).
Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver diseases or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide administration.
Thiazide drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the post-sympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.
If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.
Thiazides may decrease serum PBI levels without signs of thyroid disturbance.
Calcium excretion is decreased by thiazides. Pathological changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS
Reserpine: *Gastrointestinal*—hypersecretion; nausea; vomiting; anorexia; diarrhea. *Cardiovascular*—angina-like symptoms; arrhythmias (particularly when used concurrently with digitalis or quinidine); bradycardia. *Central Nervous System*—drowsiness; depression; nervousness; paradoxical anxiety; nightmares; rare parkinsonian syndrome and other extrapyramidal tract symptoms; CNS sensitization (manifested by dull sensorium, deafness, glaucoma, uveitis, and optic atrophy). *Miscellaneous*—frequently nasal congestion; pruritus; rash; dryness of mouth; dizziness; headache; dyspnea; syncope; epistaxis; purpura and other hematological reactions; impotence or decreased libido; dysuria; muscular aches; conjunctival injection; weight gain; breast engorgement; pseudolactation; gynecomastia; rarely water retention with edema in hypertensive patients.
Hydralazine: *Common*—headache; palpitations; anorexia; nausea; vomiting; diarrhea; tachycardia; angina pectoris. *Less frequent*—nasal congestion; flushing; lacrimation; conjunctivitis; peripheral neuritis, evidenced by paresthesias, numbness, and tingling; edema; dizziness; tremors; muscle cramps; psychotic reactions characterized by depression, disorientation, or anxiety; hypersensitivity (including rash, urticaria, pruritus, fever, chills, arthralgia, eosinophilia, and, rarely, hepatitis); constipation; difficulty in micturition; dyspnea; paralytic ileus; lymph adenopathy; splenomegaly; blood dyscrasias, consisting of reduction in hemoglobin and red cell count, leukopenia, agranulocytosis and purpura; hypotension; paradoxical pressor response.
Hydrochlorothiazide: *Gastrointestinal*—anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis, sialadenitis. *Central Nervous System*—dizziness, vertigo, paresthesias, headache, xanthopsia. *Hematologic*—leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. *Cardiovascular*—orthostatic hypotension (may be potentiated by alcohol, barbiturates, or narcotics). *Hypersensitivity*—purpura, photosensitivity, rash, urticaria, necrotizing angiitis, Stevens-Johnson syndrome, and other hypersensitivity reactions. *Other*—hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSAGE
As determined by individual titration (see box warning).
Usual dosage is 1 or 2 tablets t.i.d. For maintenance, adjust dosage to lowest patient requirement. When necessary, more potent antihypertensives may be added gradually in dosages reduced by at least 50 percent.

HOW SUPPLIED
Tablets (light salmon pink, dry-coated), each containing 0.1 mg reserpine, 25 mg hydralazine hydrochloride, and 15 mg hydrochlorothiazide; bottles of 30, 60, 100, 1000 and Accu-Pak® blister units of 100.
Consult complete literature before prescribing.

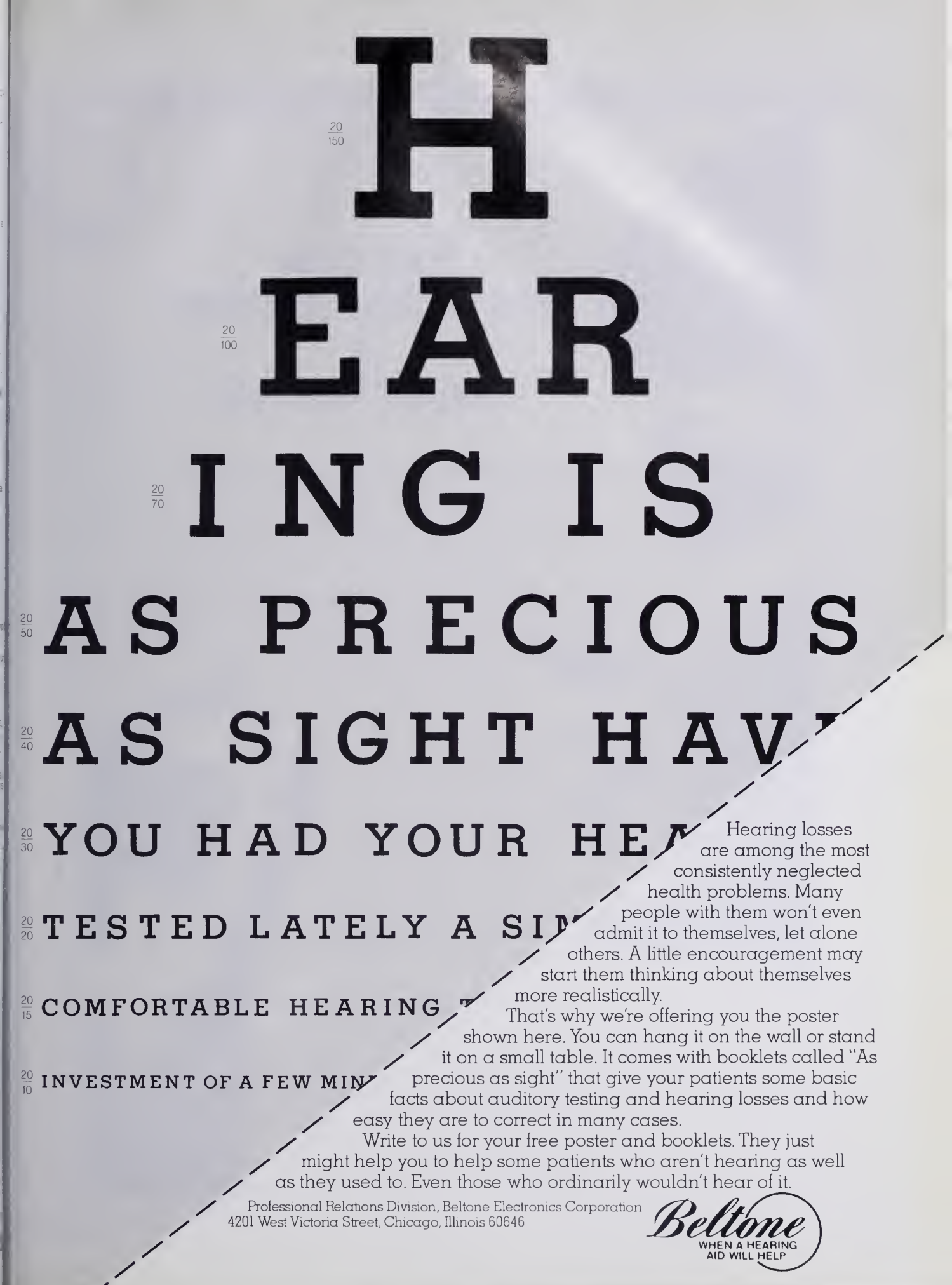
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Summit, New Jersey 07901

Reference

1. Stamler J, Stamler R, Riedlinger WF, et al: Hypertension screening of 1 million Americans. *JAMA* **235**:2299-2306, 1976.

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A Survey of Blood Pressure in 1,305 Normal Neonates

William Fanizzi, M.D., Kamal Taslimi, M.D. and Anthony Vasquez, M.D.

Abstract: Systolic and diastolic blood pressure was determined by a Doppler ultrasound instrument on 1,305 normal neonates in three community hospitals by the nursing staff. The mean value was 65/35 mm Hg (SD=11/11 mm Hg). There was a small increase in blood pressure with increasing neonatal weight and with increasing neonatal length. There was no relationship between neonatal blood pressure and maternal blood pressure, maternal age or parity. Neonatal blood pressure did not differ between sexes or among races.

The development and validation of a Doppler ultrasonic instrument for accurate neonatal systolic and diastolic blood pressure determination has made it feasible to measure blood pressure on all neonates.[1-4] This study was performed to determine the mean brachial artery blood pressure in a large series of normal neonates. In addition, data were collected to study the relationship of neonatal blood pressure to sex, race, neonatal size, maternal blood pressure, maternal age and maternal parity.

Materials and Methods

A total of 1,305 neonates at three hospitals in Broward County, Florida* were studied. Each infant had been examined and judged normal by one of us. Prenatal records provided maternal blood pressure, age and parity. Neonatal brachial blood pressures were determined by the nursing staff, using an ultrasonic Doppler blood pressure instrument** with 17 cm x 4.7 cm cuff (Fig. 1). The data were computer analyzed. The means, standard deviations, and ranges were determined. In addition, correlation coefficients, regressions, and tests for statistical significance were used to compare neonatal and maternal blood pressures.

Results

The mean, standard deviation (SD) and range of neonatal brachial artery blood pressures by sex and race are shown in Table 1. The pressures were determined during the first six hours of life in 72% of cases and in the first 24 hours in 77%. Of the 1,305 neonates, 1,121 (86%) were Caucasian, 178 (13.6%) were Black, and 665 (51%) were male. The mean brachial pressure was similar for all groups and averaged 65.0/35.2 mm Hg. The SD was typically close to 11 mm Hg for the systolic and diastolic values. The maximum pressures recorded were 102 mm Hg systolic and 80 mm Hg diastolic. There were no significant racial or sexual differences.

Table 2 shows the relationship of brachial blood pressure to neonatal weight and length. There is an increase in blood pressure with increasing size. Typically the largest neonate had systolic and diastolic pressures 5 mm Hg higher than the smallest infant. No attempt was made to correlate gestational age with blood pressure.

This study was sponsored by the Broward County Heart Association.

*Hollywood Memorial Hospital, Broward General Medical Center, Holy Cross Hospital.

**ARTERIOSONDE® 1010, Roche Medical Electronics Inc., Cranbury, New Jersey.



Fig. 1.—The Doppler ultrasound instrument is designed to permit measurement of neonatal blood pressure in a manner similar to that of an adult. A cuff and transducer are wrapped around the arm. The cuff is inflated and slowly deflated. The aneroid gauge is observed and the sounds heard from the instrument's speaker are interpreted as if they were Korotkoff sounds.

Table 1.—Neonatal Blood Pressure.

Race/Sex	Number of Neonates	Mean BP (mm Hg)	Standard Deviation (mm Hg)	Minimum BP (mm Hg)	Maximum BP (mm Hg)
BRACHIAL SYSTOLIC BLOOD PRESSURE (mm Hg)					
Caucasian Male	572	65.8	10.9	38.	102.
Caucasian Female	549	65.6	10.5	40.	102.
Black Male	91	64.6	10.3	36.	96.
Black Female	87	64.9	10.9	20.	85.
Oriental Male	2	68.0	5.7	64.	72.
Oriental Female	3	62.0	12.5	52.	76.
Not Specified	1	64.0	0.0	64.	64.
	1305 Total	65.0 Av'g.			
BRACHIAL DIASTOLIC BLOOD PRESSURE (mm Hg)					
Caucasian Male	571	34.2	11.7	14.	80.
Caucasian Female	549	34.0	11.0	15.	70.
Black Male	91	32.2	11.4	16.	62.
Black Female	88	31.5	11.0	16.	58.
Oriental Male	2	34.0	5.7	30.	38.
Oriental Female	3	36.7	14.2	24.	52.
Not Specified	1	44.0	0.0	44.	44.
	1305 Total	35.2 Av'g.			

Table 2.—Relation of Neonatal Size to Brachial Blood Pressure.

Weight (grams)	Number of Neonates	Mean BP (mm Hg)	Standard Deviation (mm Hg)	Minimum BP (mm Hg)	Maximum BP (mm Hg)
BRACHIAL SYSTOLIC BLOOD PRESSURE (mm Hg)					
<2000	15	62.9	13.8	36.	92.
2000—2999	239	61.6	10.2	38.	100.
3000—3999	917	65.9	10.3	20.	102.
4000—4999	120	69.9	11.9	44.	102.
5000+	6	70.0	13.6	50.	88.
BRACHIAL DIASTOLIC BLOOD PRESSURE (mm Hg)					
<2000	15	31.3	12.2	20.	50.
2000—2999	239	31.7	10.1	14.	64.
3000—3999	917	34.1	11.3	15.	80.
4000—4999	120	36.1	12.1	18.	62.
5000+	6	44.0	14.5	20.	60.
BRACHIAL SYSTOLIC BLOOD PRESSURE (mm Hg)					
Length cm / inches					
40.6 / 16	2	65.0	9.9	58.	72.
43.2 / 17	8	60.0	8.9	50.	76.
45.7 / 18	30	63.5	11.0	42.	90.
48.3 / 19	188	64.1	9.5	38.	90.
50.8 / 20	264	66.5	9.4	46.	100.
53.3 / 21	73	67.6	10.8	50.	100.
55.9 / 22	14	72.8	11.8	58.	100.
58.4 / 23	1	70.0	0.0	70.	70.
BRACHIAL DIASTOLIC BLOOD PRESSURE (mm Hg)					
40.6 / 16	2	35.0	15.6	24.	46.
43.2 / 17	8	30.3	12.2	20.	48.
45.7 / 18	30	31.8	10.0	20.	52.
48.3 / 19	188	34.5	10.2	15.	62.
50.8 / 20	263	38.7	10.0	20.	62.
53.3 / 21	73	39.7	10.3	20.	66.
55.9 / 22	14	43.9	9.3	30.	60.
58.4 / 23	1	54.0	0.0	54.	54.

Table 3.—Neonatal Blood Pressure. Maternal Age and Parity

Maternal Age (Years)	Number of Neonates	Mean BP (mm Hg)	Standard Deviation (mm Hg)	Minimum BP (mm Hg)	Maximum BP (mm Hg)
BRACHIAL SYSTOLIC BLOOD PRESSURE (mm Hg)					
No Entry	591	65.6	11.2	40.	102.
15—19	83	65.5	11.0	42.	92.
20—24	216	64.9	9.8	42.	100.
25—29	277	65.1	10.3	20.	100.
30—34	101	67.5	9.7	46.	94.
35—39	25	65.5	9.4	42.	80.
40+	11	60.4	9.2	48.	80.
BRACHIAL DIASTOLIC BLOOD PRESSURE (mm Hg)					
No Entry	592	30.2	11.5	14.	80.
15—19	83	36.9	10.0	20.	62.
20—24	215	36.1	10.0	20.	70.
25—29	277	37.0	10.9	20.	68.
30—34	101	38.1	9.3	20.	52.
35—39	25	37.5	10.3	20.	52.
40+	11	31.6	7.6	20.	40.

Maternal Parity					
	BRACHIAL SYSTOLIC BLOOD PRESSURE (mm Hg)				
1	271	65.0	10.3	36.	100.
2	126	65.0	10.1	20.	94.
3	52	64.2	10.9	46.	86.
4	22	66:0	11.0	52.	100.
5	11	67.8	11.0	48.	90.
6	4	60.5	17.5	42.	80.
7	3	60.1	5.0	56.	66.
9	1	62.0	0.0	62.	62.
	BRACHIAL DIASTOLIC BLOOD PRESSURE (mm Hg)				
1	271	36.1	10.9	15.	62.
2	126	35.8	9.5	20.	68.
3	52	38.6	9.6	20.	60.
4	22	36.2	8.6	20.	58.
5	11	38.0	9.9	20.	50.
6	4	31.5	13.0	20.	50.
7	3	31.3	9.9	20.	38.
9	1	40.0	0.0	40.	40.

Comparing the measured neonatal blood pressure with the mother's blood pressure during pregnancy and postpartum revealed no correlation.

Discussion

This study reports the blood pressures in 1,305 normal neonates born in three south Florida community hospitals under normal circumstances. There were no blood pressure differences between males and females or between Caucasians and Blacks. The mean value of 65/35 mm Hg is in agreement with the findings of others in this age group.[5] As expected neonatal blood pressure increases with increasing neonatal size. These data corroborates those in the literature.[1-7]

Conclusions

1. The blood pressure of the normal neonate is 65/35 mm Hg, SD ± 11/11 mm Hg.
2. Blood pressure is related to the size of the neonate.
3. There is no apparent relation of neonatal blood presure to maternal blood pressure, age or parity.
4. Using Doppler ultrasound, the nursing staff could easily obtain the blood pressure in all neonates.

Acknowledgements

The data were collated and processed by Roche Medical Electronics, Cranbury, New Jersey 08512. We would like to thank Mr. Hamilton H. T. Chang of Roche for the programming and computer efforts involved.

References

1. Hochberg, H. M. and Saltzman, M. B.: Accuracy of Ultrasound Blood Pressure Instrument in Neonates, Infants, and Children, Curr. Therap. Res. 13:482-488, 1971.
2. Hochberg, H. M.: Accurate Non-invasive Measurement of Blood Pressure in Neonates, Infants and Children by Ultrasonic Techniques, Pediatrics Digest 15:33-39, 1973.
3. Massie, H. L. et al: Ultrasonic Measurement of Infant Blood Pressure, Med. Instrum. 7:240-244, 1973.
4. Dweck, H.; Reynolds, D. W., and Cassidy, G.: Indirect Blood Pressure Measurements in Newborns, Am. J. Dis. Child. 127:492-494, 1974.
5. Rance, C. P.; Arbus G. S.; Balfe, J. W., and Koon, S. W.: Persistent Systemic Hypertension in Infants and Children, Pediatric Clin. N. A. 21(4):801-824, 1974.
6. Modanlou, H.; Yeh, S.; Siassi, B., and Hon, E. H.: Direct Monitoring of Arterial Blood Pressure in Depressed and Normal Infants During First Hour of Life, J. Ped. 85:553-559, 1974.
7. Kitterman, J. A.; Phibbs, R. H., and Tooley, W. H.: Aortic Blood Pressure in Normal Newborn Infants During First 12 Hours of Life, Pediatrics 44:959-968, 1969.

▶Dr. Fanizzi, 919 East Broward Boulevard, Fort Lauderdale 33301.

Some men see things as they are and say, why.
I dream things that never were and say, why not.
Robert F. Kennedy

Evaluation of Hypertension

Michael J. Pickering, M.D.

Abstract: Hypertension in the American population is a common entity. An estimated 20 to 40 million people are affected and 30% to 50% of the end stage renal disease population have nephrosclerosis, the end result of sustained hypertension. Documented studies have shown the incidence of strokes can be significantly reduced by careful management of the hypertensive patient.

Using a conservative 20% as the incidence of hypertension in the State of Florida would indicate there are approximately 1.6 million patients with the abnormality. Evaluation of them must be judicious in expenditure of time and money. With the approach of a good history, careful physical examination, judicious use of the laboratory, and proper evaluation, one should be able to confidently treat these patients. With effective management the cost of medical care should not be restrictive in dollars or manpower.

Hypertension is a serious entity. It is quite likely the most prevalent devastating disease in the United States at present.

To preface the following remarks, you should be aware that I feel like an evangelist preacher. I have been preaching the following sermon for some time and I, like him, believe it. However, it is hard to bring the converts to the altar. I hope by the end of this paper you will believe two things: (1) Elevated blood pressure is bad; (2) All elevated blood pressure should be treated.

The Yellow Emperor's Classic of Internal Medicine, written in the 26th century B.C. states, "When a pulse is stone like, but also like the beating of a hammer, a disease will make its appearance. . . . when the pulse is tense and hard, and full like a cord, there are dropsical swellings . . . (and then, showing that Yellow Emperors can also be wrong) . . . the heart rules over the kidneys . . . thence, if too much salt is eaten, the pulse hardens." Preempting Dr. Lewis K. Dahl and Dr. Arthur Guyton by a number of centuries, these early physicians treated hypertension by venesection or acupuncture.

Through the centuries the Egyptians, Chinese, Greeks, Jews and Arabs recognized that rampant emotions, intemperate eating and excessive strain in the arms of a concubine could be fatal to a man with aged arteries.

Following the third century A.D., the inquisitive nature of the scientists quieted as medicine fell into the hands of the barber surgeons, combining the belief of the four humors, cautery, witchcraft and the devil.

In 1028 A.D. Harvey published, De Motu Cordis, describing the circulation. Yet, 80 years elapsed before the scientific demonstration of the reality of blood pressure occurred. In December 1711, Reverend Stephen Hales, "caused a mare to be tied down alive on her back . . . and inserted a brass pipe, whose bore was 1/16 of an inch into the left crural artery and attached a nine foot length of glass tubing of a similar diameter. The blood rose 8 feet and 3 inches." The selection of a nine foot tube suggests the Reverend had attempted the experiment before and had probably gotten wet.

Finally, in 1828, Poisueille connected a mercury filled U-tube to a canulated artery. Since mercury is 13.6 times more dense than blood, indoor measurements could be done.

Evidence of the effects of hypertension began in 1836 when Richard Bright[1] noted "an altered quality of blood affords irregular and unwanted stimulus to the heart immediately." In 1874 Frederick Henry Horatio Akhbor Mahomed[2] noted that hypertension may precede the albuminuria noted previously by Dr. Bright. Dr. Mahomed was likely the first to describe essential hypertension a year later in an article in 1879.[3]

Excellent epidemiologic studies started in the 1940s were reported by Kannel et al. in the Annals of Internal Medicine in 1961, demonstrating the risk of coronary artery disease in hypertensive patients. Dr. Edward D. Freis, in the now well publicized

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Veterans Administration cooperative study,[4] clearly demonstrated the increased risk of coronary disease and stroke in hypertensive individuals. The Framingham study reported by Kannel et al. in 1970 vividly depicted a relationship of hypertension to stroke.[5] They concluded that the most important contribution to the increasing incidence of atherothrombotic brain infarction was hypertension, whether labile, fixed diastolic or systolic in men and women. Dr. D. G. Wombolt[6] found that 44% of his patients on chronic dialysis at Norfolk, Virginia, had hypertensive nephrosclerosis as the etiology of their end stage renal disease.

With the well documented clinical evidence of the deleterious effects of hypertension combined with the numerous experimental studies, one should have little doubt that hypertension is indeed bad.

The incidence of hypertension is difficult to ascertain. Various criteria are used, populations vary, methods of measuring vary and the bias of the data collector is always introduced. Regardless of these frailties, hypertension has been documented to be a very prevalent entity. From the available data, 15% to 20% of the white population and 20% to 40% of the black population in the United States have hypertension, using 150/90 as a basis. Therefore, between 20 and 40 million people have the abnormality.

Evidence of treatment benefit is quite well documented. The excellent study produced by the Veterans Administration, headed by Dr. Freis,[7] showed that lowering blood pressure in patients with diastolic pressure of over 105 mm Hg significantly decreased the mortality and morbidity rate. In fact, it became so obvious, the study was broken to begin treating those in the control group. Dr. Freis also reported in 1972 that rats with spontaneous hypertension could be completely protected from the cardiovascular lesions by medically lowering pressure to normal. Taguchi[8] reported that even partial lowering of pressure has a salubrious effect on mortality.

The insurance actuaries have provided us with the most pertinent data concerning the effects of hypertension. Data they have collected over the past 50 years demonstrates these facts: 1. 100/60 mm Hg blood pressure is the ideal pressure for the maximum longevity. 2. Longevity decreases as pressure rises from this point.

The few remaining philosophers that argue there is yet no double blind cleverly devised study showing a salubrious outcome in the treatment of mild hypertension are either arguing to argue, have not digested what they have read and seen, or have not read or seen.

The categorization of hypertension has been a fun game for many writers. Some do it by differentiating the systolic and diastolic blood pressure; others, by primary and secondary criteria. For the purpose of general evaluation of the hypertensive patient, one need only be concerned whether the patient does or does not have a surgically remediable cause of his blood pressure elevation. Presently, there are few such patients. Probably the most common correctable causes of hypertension are renal artery diseases of the arteriosclerotic and fibromuscular types. Primary aldosteronism, although correctable with surgery, can usually be treated. Pheocromocytomas and coarctations of the aorta, although quite rare, are best treated by surgery at the present time.

The literature is heavy with outlines, graphs, step procedures and even algorithms concerning the evaluation, or workup, of the hypertensive patient. I offer the following biased self-satisfying approach to this problem.

I. History: The single most important aspect of the initial evaluation is a good comprehensive history of the patient. The complete history should be addressed to the following items:

 A. Duration: A search for the longevity of known hypertension should be carried out. Asking of previous insurance physicians, physicals upon entering or leaving the armed forces, etc., should be exhaustive. A known history of hypertension of many years is most commonly associated with physiologic hypertension. Known high blood pressure for only three years is the average time of a patient with renal artery disease.

 B. Significant change in blood pressure: Long standing mild blood pressure that suddenly becomes markedly exacerbated should alert one's attention to superimposed renal artery disease or possibly the malignant phase of physiologic hypertension.

 C. Response to prior treatment: Physiologic hypertension of mild to moderate variety usually responds to a variety of drugs in mild to moderate doses. Severe renal artery disease or marked primary renal disease are difficult to manage with most medications.

 D. Associated symptoms: Excessive perspiration, severe headaches and episodic blanching are associated with metabolic diseases such as hyperthyroidism and/or pheocromocytoma. The patient with primary hyperaldosteronism commonly presents with polyuria, nocturia and muscular weakness. Occasionally the Cushing's patient has the same symptoms.

 E. Urinary tract infections and stones: These are commonly seen with primary renal disease and hyperparathyroidism as an etiology of hypertension.

 F. Family history: A family history of hypertension is extremely common in the physiologic hypertensive patient. A previous history of

family members having diabetes mellitus would certainly encourage one to rule out this underlying disease.

II. Physical examination: As usual, the physical examination should be done to correlate the historical suspicions aroused and hopefully to put the hypertension in possible categories. The examination should be complete but careful attention paid to the following:

A. Proper measurement of the pressure.

1. Cuff should be of proper size. The standard 5 inch cuff will give falsely high readings in an obese or very muscular individual. The pressure will be spuriously low in a very thin arm. The 3 inch or 7 inch cuff should be available to more nearly approximate the true blood pressure.
2. The position of the arm should be near the height of the heart, since gravity changes the pressure recordings.
3. Lying and standing pressures should be recorded. There is good evidence that the character of the blood pressure, upon standing, relates to the severity of the disease. Dr. Dustin at the Cleveland Clinic has shown this quite well. It is also advantageous to have a baseline of the lying and standing pressures so that when medication is started hypotensive effects can be readily appreciated.
4. Both arm pressures should be recorded to incriminate atherosclerotic vascular disease.
5. Character of the pulse should be noted. This is especially helpful in atherosclerotic vascular disease, hyperthyroidism, AV fistulas and coarctations of the aorta.
6. Heart sounds should be noted carefully. Character of a second heart sound should be carefully recorded and the presence or absence of a fourth heart sound noted. This is commonly heard in hypertensive patients.
7. Bruits of the abdomen and vessels: 50% of patients with renal artery stenosis have bruits under the costal margins in the upper abdomen. Midline bruits in the abdomen are probably of little relevance. Bruits over the peripheral vessels or abdominal aorta are usually associated with atherosclerotic vascular disease.
8. Abdominal examination: One looks carefully for the enlarged, slightly tender nodular polycystic kidneys as well as aneurysms of the aorta.
9. Fundi: Since this is the only place we can directly look at small vessels, it affords us a great opportunity to determine if end organ disease is likely in this particular hypertensive patient. One should look for narrowing of the arterioles and spastic changes in the small vessels for the hypertensive deleterious effects, while AV nicking or crossing changes are noted to reflect more atherosclerotic vascular changes.

III. By now, one should have coned down on the most likely etiology of the hypertension. The laboratory evaluation should be limited to those items that will give information to confirm the diagnosis or provide data that the history and physical cannot supply. Attention to diet and drugs is critical before launching the SMA dreadnaught. The laboratory evaluation for the hypertensive patient should be as follows:

A. CBC: Polycythemia and chronic renal disease are readily detected by changes in the hemoglobin or hematocrit. Frequently, elevated hematocrits are seen with pheocromocytoma due to the resulting contracted plasma volume often referred to as Gaisbock's syndrome. Burr cells and irregular red cells are often seen with malignant hypertension.

B. Urinalysis: The doctor should look and stick the urine for best results. The specific gravity is quite nonspecific, but can give some indication as to the tubular concentrating ability. The sediment should be carefully evaluated so that primary renal disease with the attendant casts, etc., can be noted. Proteinuria should be quantitated.

C. Electrolytes: Primary or secondary hyperaldosteronism typically produces hypokalemic alkalosis. One must be most mindful of drug and diet interference when interpreting electrolyte data.

D. Serum creatinine: This certainly diagnoses primary renal disease by its elevation. BUN can be very misleading due to dietary influences and should be used to control the protein intake in the chronic uremic.

E. Electrocardiogram and chest x-ray: These two tests provide information concerning the end organ damage done by the previous hypertension and give a yardstick to measure the effectiveness of our therapy. The chest x-ray often is diagnostic of the aorta.

F. Two hour blood sugar and cholesterol: These two, if abnormal, are added risk factors and should encourage more vigorous approach to their correction and to the treatment of hypertension.

The absence of a peripheral renin determination in the laboratory evaluation of the hypertensive patient is intentional. The commercial kits available to laboratories are usually accurate, but considerable experience is needed to perfect the normal range as related to position and salt intake. Therefore, unless the laboratory and the physician are performing adequate numbers of tests, there will be little confidence generated. If this has been done, significant information can be obtained. As Dr. Laragh[9] has demonstrated, approximately 20% of physiologic hypertensive patients will have hyperreninemia; 50% to 60% will have normoreninemia and the rest hyporeninemia. The high renin patients respond well to peripheral dilators and beta blockers. Those with low renin usually do well with aldosterone inhibiting diuretics. The normal renin group responds to both. Therefore, a sophistication of treatment can be introduced. The peripheral renin cannot predict the presence of renal artery stenosis.

After the history, physical and laboratory evaluation, the patient should now be readily classifiable. Since 80% to 85% of the hypertensive population falls into the physiologic hypertensive group, the history will probably reveal a long duration of mild to

moderate hypertension that has not significantly changed in the recent past and has responded well to various prior treatments. The physical examination will show minimal end organ damage as indicated by the electrocardiogram and chest x-ray and mild vascular changes of the funduscopic exam. Often these will be completely normal. There will likely be no abdominal bruits under the costal margins, the pulses will be normal and the heart sounds are normal, except frequently a fourth heart sound will be present. The electrolytes, CBC, creatinine will be normal and, if no history of diabetes in the past, the cholesterol and blood sugar might well be normal. The more sophisticated laboratory studies available should be performed only when the above ABC's of the evaluation of hypertension have directed the doctor toward a diagnosis of a potentially correctable disease.

If renal artery disease is suspected by historical and physical evaluation, one should obtain a hypertensive intravenous pyelogram, looking for disparity in size of the kidneys, a difference in contrast concentration and in the rapidity of clearance of the dye from each kidney. A 20% to 30% false negativity is inherent in this test and if one has historical data showing a drastic recent change in the elevation of blood pressure or evidence of marked difficulty in the control of the pressure, especially in an individual under 40 years of age, further evaluation should be done in the face of a negative hypertensive IVP. The selective renal arteriogram is the most definitive diagnostic procedure available at this time. The morbidity and mortality associated with the arteriogram should be insignificant in competent hands. During the years 1970-1975, the radiologists at the Watson Clinic had no mortality and the only morbidity noted was hematoma formation at the site of puncture. This occurred in less than 5% of patients. If there is a constriction noted on the arteriogram, one must then perform either a differential renin test from the renal veins and/or the Stamey-Howard split function test. Since there is considerable morbidity associated with the Stamey-Howard test, it has fallen into disuse. The decision to perform the differential renin test is predicated on the assumption that the laboratory performing it has a competent system so one can give great confidence to a twofold increase in the renin concentration on the affected vein as opposed to the unaffected vein. There is a 95% confidence associated with this twofold difference[10] in that surgery will greatly benefit the patient. If surgery is indicated one then must have a surgeon who has developed some experience with renal artery surgery. Again, the mortality rate of unilateral renal artery surgery should be very low. In 25 consecutive patients undergoing renal artery surgery, we experienced no fatalities.

The advent of the computerized nuclear scanning techniques may offer help in the future for the evaluation of renal artery disease by a noninvasive procedure. At this time the validity of the nuclear scan is not completely established. Intrarenal hemodynamic alterations can mimic renal artery disease and we have found one case where the nuclear scan was completely normal with a demonstrated 98% occlusion by renal arteriography.

If history revealed polyuria, nocturia and marked muscular weakness and, if the physical exam was normal but a serum potassium was found to be low, one should suspect primary aldosteronism. This adrenal abnormality can be easily diagnosed by first establishing hypokalemia without the effect of diurectics or an alteration in diet on three occasions. Following this, give 200 mEq of sodium for three days and measure a 24 hour urine for potassium. If the serum potassium is low and there is over 50 mEq of potassium in the urine, the test is positive for hyperaldosteronism. To differentiate from primary aldosteronism, a suppression test is needed. Three days of suppression by a mineralocorticoid producing a serum aldosterone of under 5 ng/ml is confirmatory of secondary hyperaldosteronism. If it suppresses no more than 10 ng/ml, the diagnosis is either an adenoma or hyperplasia of the adrenal gland. To separate primary bilateral hyperplasia from an isolated adenoma, one should give spironolactone 400 mg a day and if the pressure returns to normal, bilateral hyperplasia would be most likely. Again, if one has confidence in the renin levels, the findings of a very low renin on normal salt intake would help confirm the diagnosis of hyperaldosteronism.

Pheocromocytomas are rare and should be evaluated only if a good historical background is presented. Episodic blanching, excessive sweating and constipation are usual symptoms. The best available test at present is the ratio of metanephrine and normetanephrine to the creatinine in a random urine. A one to one ratio is considered normal.

Other underlying diseases associated with hypertension should be kept in mind and searched out if need be. Hyperparathyroidism, hyperthyroidism, somatotropin, and Cushing's disease usually present with a fairly characteristic history and physical, spectrum of symptoms and signs, and confirmatory laboratory tests.

Summary

With the approach of a good history, a careful physical examination and the judicious use of the laboratory, one should be able to confidently treat the hypertensive patient. With this approach, the cost should not be restrictive in dollars or in manpower. Remember, hypertension is bad, therefore, treat it.

References

1. Bright, R.: Tabular Views of the Morbid Appearance in 100 Cases Connected with Albuminous Urine with Observations, Guy's Hospital Rep. 1:380-400, 1836.
2. Mahomed, F. A.: Etiology of Bright's Disease and the Pre-albuminuric Stage, Med-Chir Trans. 57:197, 1874.
3. Mahomed, F. A.: Some of the Clinical Aspects of Chronic Bright's Disease, Guy's Hospital Rep. (3rd series) 24:363-418, 1879.
4. Veterans Administration Cooperative Study Group on Antihypertensive Agents: Effects of Treatment on Morbidity in Hypertension: Results in Patients with Diastolic Blood Pressure Averaging 115 through 125 mm. Hg., JAMA 202:1028-1034, 1967.
5. Kannel, W. B.; Phillips, A. W., and Vector, et al: Epidemiologic Assessment of Role of Blood Pressure in Stroke. The Framingham Study, JAMA 214: 301-370 (Oct. 12), 1970.
6. Wombolt, D. G., et al: Maintenance Hemodialysis in Patients with End Stage Renal Disease. Abstract, Southeastern Dialysis and Trans. Assoc. (Aug.) 1975.
7. Veterans Administration Cooperative Study Group on Antihypertensive Agents: Effects of Treatment on Morbidity in Hypertension: II. Results in Patients with Diastolic Blood Pressure Averaging 90 through 114 mm. Hg., JAMA 213:1143-1152, 1970.
8. Taguchi, J. and Freis, E. D.: Partial Versus Complete Control of Blood Pressure in the Prevention of Hypertensive Complications, Circ. Res. 36 (Supp. 1):257-260, 1975.
9. Laragh, J. H.: Approach to Classification of Hypertensive States, Hospital Practice, pp. 61-73, January 1974.
10. Marks, L. S.; Maxwell, M. H., and Kaufman, J. J.: Appraising Renal Vein Renin Ratio, Hypertension Vol. 1, No. 3:7-12, August 1975.

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PARKINSON'S DISEASE INFORMATION SERVICE ESTABLISHED IN ATLANTA

The American Parkinson Disease Association has opened an information service in Atlanta.

"This is to be an information and referral service only," according to John E. Lee, M.D., Medical Director. "No patient care will be given by our staff."

Dr. Lee explained the Service will provide the public with information about the disease, its treatment, where to obtain medical help and physical therapy services.

Physicians interested in being included on the referral list should write to: Parkinson's Disease Information Service, 25 Prescott St., Atlanta, Ga. 30308, telephone 1 (404) 892-6995. They should include their name, office address, and office telephone number.

Rhabdomyosarcoma of the Head and Neck in Children

Recent Experience at the University of Florida

John J. Rooks Jr., M.D. and Mutaz B. Habal, M.D.

Abstract: Rhabdomyosarcoma is the most common type of soft tissue sarcoma in children. It most frequently is seen in the head and neck regions. A clinical review of the material is presented with four illustrative cases. Our mullidisciplinary team approach to this disease is outlined, and the criteria for craniofacial resection is presented.

Rhabdomyosarcoma is the most common type of soft tissue sarcoma in children and is most frequently seen in the head and neck region, according to many series.[1] It represents 10%-15% of childhood malignant tumors and 5%-8% of all childhood malignant diseases. The most common age incidence is between four and five years. The tumor arises from pleuripotential embryonic cells, either immature prospective muscle tissue or undifferentiated mesenchymal cells with potential for aberrant differentiation of muscle fibers.[2] The disease all too frequently has a fulminant course with rapid development of either local recurrence or distant metastasis. Death frequently occurs within one year of diagnosis.[3] It has been shown that 70% recur locally in the first year and 90% within the second year.[4]

Histopathologically, there are four types of childhood rhabdomyosarcoma: embryonal, alveolar, pleomorphic and, botryoid. In the head and neck region, embryonal type is more frequently encountered. These lesions are composed primarily of small, round, and spindle shaped rhabomyoblasts.[5]

The diagnostic evaluation of these patients when first seen has to be thorough before treatment begins and usually consists of a complete history and physical examination. This is followed by complete blood supplies to evaluate the hematologic and renal systems. A bone marrow profile is performed and special roentgenograms of the chest, long bones, spine, and skull are ordered. Arteriograms and computerized axial tomography are requested as needed. A photograph of the primary lesion is made in all cases.

When this is complete, the patient can be properly staged, i.e.:

Stage I. —Localized disease; completely resectable.

Stage II. —Regional disease; adjacent structures or local and regional nodes involved.

- (A) Completely resectable.
- (B) Nonresectable or partially resectable, i.e., pelvic lymph node involvement from sarcoma botryoides, or involvement of base of skull from a nasopharyngeal primary.

Stage III.—Generalized disease

- (A) Distant metastasis with normal bone marrow.
- (B) Distant metastasis with positive bone marrow.

Distribution in the head and neck area as to frequency of occurrence is: nasopharynx, ear and mastoid, soft tissues of face, tongue, orbit, maxilla, nose and peritonsillar areas.

Most medical programs now agree that the approach to this tumor is a multidisciplinary effort with each patient being evaluated by a team consisting of surgeons, radiotherapists, and chemotherapists. There are many considerations which must be held accountable in the head and neck area such as surgical accessibility. Newer techniques have recently been developed which have changed the surgical approach to these lesions, i.e., craniofacial resection, so that some areas are now more

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accessible. This concept of surgery differs from the usual radical exenteration in that it includes not only the soft tissues but the adjacent bone at the base of the skull which is either involved by tumor or acts as a barrier for clear tumor margins. For instance, if we are dealing with an orbital tumor, our resection would include the circumorbital soft tissues, entire bony orbit, ethmoidal, frontal, maxillary, and sphenoidal sinuses, and all soft tissues from the frontal lobe to the palate. Involved dura is resected with the specimen and autogenous fascia lata or galea is used as a free dural graft. Reconstruction is usually delayed at least for one year so that the patient may be closely monitored for local recurrences.[6] A skin graft may be applied to the dura directly.

The craniofacial surgical team consists of the otolaryngologist, plastic surgeon, and neurosurgeon. We do not recommend this surgery alone for all tumors occurring in the region of the base of the skull; however, these procedures are performed in combination with x-ray therapy and adjuvant chemotherapy. The procedures have frequently been done after x-irradiation and chemotherapy have failed. The magnitude of these procedures, which will later be illustrated in clinical case histories, demands the team approach.

Chemotherapy plays a paramount role in the treatment of these lesions. At the University of Florida our patients are clinically staged and placed on the appropriate regimen as outlined by the inter Group Rhabdomyosarcoma Study. For instance, if the patient is in Stage I, he or she is placed on a regimen which includes:

(1) Vincristine, 2 mg/M^2 IV weekly for 12 doses starting on day 0. (Maximum single dose, 2 mg).

(2) Actinomycin, 0.15 mg/kg/day, IV for 5 days starting on day 0. (Maximum single dose 0.5 mg). This first course is to be repeated at 12, 24, 36, and 48 weeks.

(3) Cyclophosphamide, 2.5 mg/kg/day orally starting on day 42 and continuing up through 24 months.

(4) Postoperative radiotherapy is given usually concomitantly. Radiotherapy doses that we have been using usually range from 5000—6000R. Generally, if the primary has occurred in the nasopharynx, radiotherapy and chemotherapy are our main modes of therapy.

For full details of these regimens, the reader is referred to the Inter Group Rhabdomyosarcoma Study's outline.[7]

Clinical Material

Four patients are now presented in detail to illustrate our multidisciplinary approach to this program. These patients are selected because of the uniqueness of their presentations and because they shed light on our recent experience and how we treat the patient who is seen to date. This does not include our entire experience with this tumor.

Case 1. — An 11-year-old female had a primary which involved the left gingivobuccal sulcus, alveolar ridge, and zygoma. At the time she presented, she had metastases in the neck and was treated with a partial excision of the tumor mass. She was then given 6000R of Cobalt 60 to the primary followed by 5000R to the left lower neck. She was treated with a chemotherapy protocol which consisted of Vincristine 2 mg/M2 per week IV for 12 weeks, Actinomycin 0.15 mg/kg per course IV for 12 weeks, and Cytoxan 10 mg p.o. daily for 24 months. She had complete regression of the tumor. Her course was complicated somewhat by dry mouth and a temporary footdrop. When last seen, she showed no evidence of disease, more than five years post-treatment.

Case 2.—A 7-year-old female was first diagnosed to have her disease in February 1975. At that time she presented with a large mass of the right preauricular area and parapharyngeal space extending into the oropharynx, base of the skull and mandible. It was believed that this represented a nasopharyngeal primary. She had bilateral neck node metastases when first seen. She was treated with 6000R Co60 to the primary with 5000R to both neck nodes, and a tracheostomy and gastrostomy were performed. She was likewise given a regimen of Vincristine, Actinomycin, and Cytoxan similar to patient number one. She had complete tumor regression but had recurrence in the right middle ear 14 months after beginning treatment. She is currently being managed with chemotherapy alone, and evaluation for craniofacial surgery revealed the tumor to be beyond the limits of resection.

Case 3.—A 10-year-old female presented to her local otolaryngologist with a chronically draining right ear with granulation tissue typical of chronic otitis media. A radical mastoidectomy was performed and pathologic evaluation of the "granulation tissue" revealed embryonal rhabdomyosarcoma. When first seen here she had no visible tumor and a mastoid series revealed no further destruction other than the surgical defect. There was no evidence of neck metastases. She was treated with radiation therapy consisting of 6000R to the primary area. This was followed by chemotherapy consisting of the VAC protocol as previously outlined. She is now one year from diagnosis and ten months since completion of radiotherapy. When last seen, she had no evidence of disease.

Case 4.—A 10-year-old girl is now over two years since initial treatment for a rhabdomyosarcoma primary in the right mandible. She previously had undergone local excision followed by 6000R irradiation. One year later recurrent rhabdomyosarcoma within the x-irradiated field developed, and she underwent a regional craniofacial procedure at that time. Chemotherapy was stopped because of delayed healing in the irradiated bed. The margins of resection were free of tumor. The next year a satellite mass suddenly appeared in the right temporal area, which was fixed to the outer table of the skull representing a marginal recurrence. The recurrence was also surgically excised with the involved neurocranium. She was started back on chemotherapy and appeared to be doing well until a mass appeared in the mastoid area one year after the surgical resection, just superior and posterior to the cervical surgical scar. The mass continued to enlarge rapidly and become quite painful. In an attempt to relieve the pain, a short course of palliative x-irradiation to the recurrence site was given. She experienced fairly prompt pain relief, but necrotic tumor debris drained from the nearby surgical excision site causing mild discomfort. Since that time no

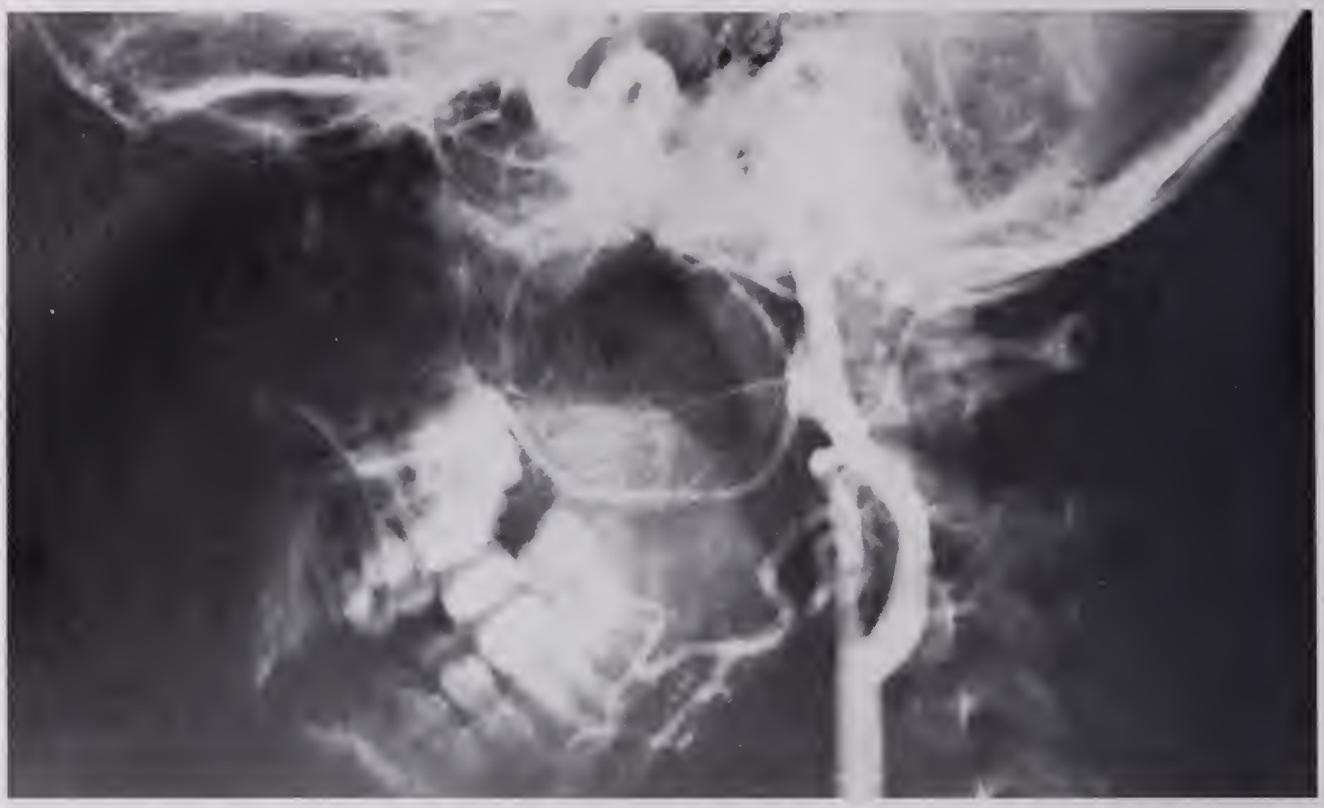


Fig. 1.—Case 4—Arteriogram revealing tumor outlined by vessels.

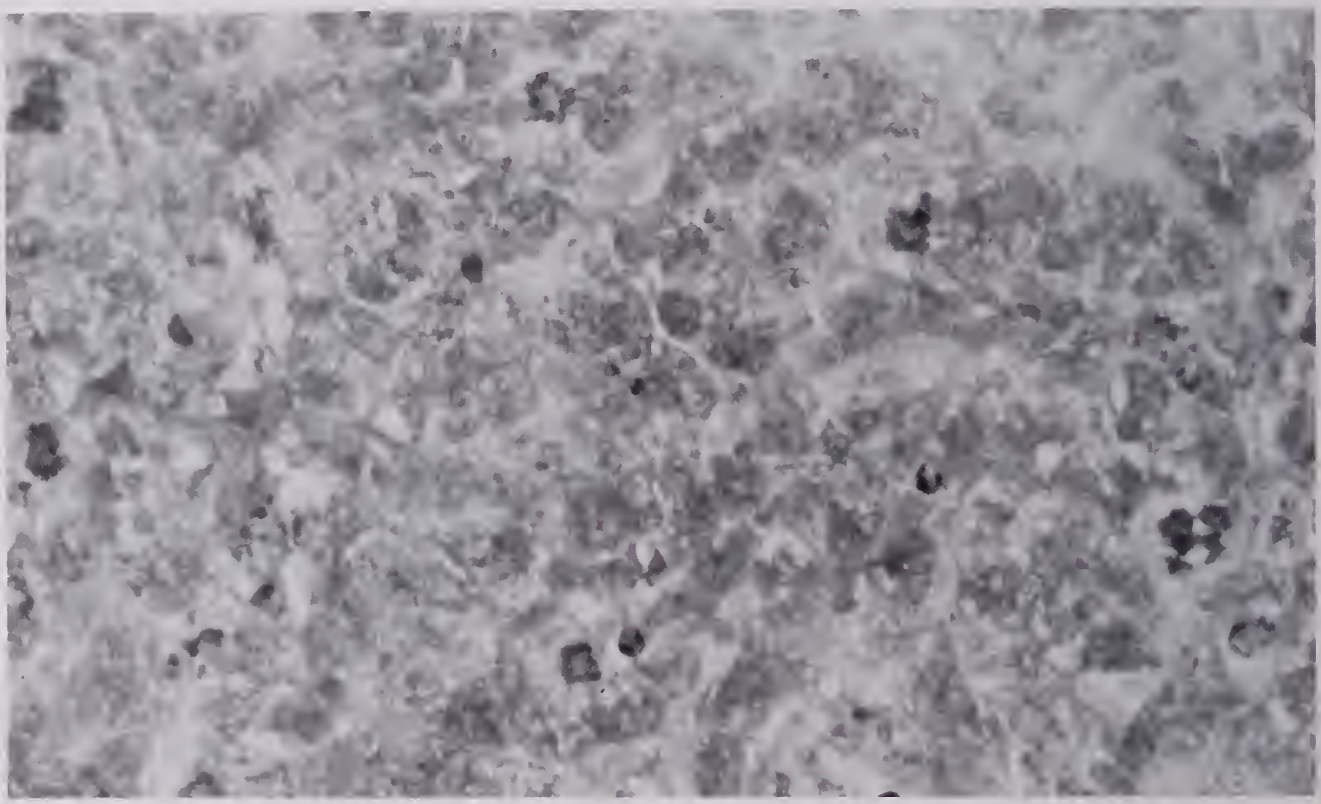


Fig. 2—Case 4—Photomicrograph (100 x magnification) of tumor—Embryonal Rhabdomyosarcoma.

further drainage has appeared and she has had excellent pain relief. She has been continued on chemotherapy with no evidence of recurrent disease.

Comments

This report has reviewed the histopathological and clinical features of rhabdomyosarcoma of the head and neck in children with stress of our current mode of treatment. We emphasize that this approach to treatment is multidisciplinary and we have outlined our experience with this clinical problem.

The newer developing techniques in craniofacial and reconstructive surgery will add to our armamentarium in the treatment of malignant diseases in the head and neck.[8] Our experience correlates with those of others in that patients with tumors arising in the orbit, parotid, or temporal areas are the best candidates for these procedures. Primary tumors arising in the nasopharynx are particularly malignant, and radiotherapy is the usual lead mode of therapy.

References

1. Sutow, W. W., et al.: Prognosis in Childhood Rhabdomyosarcoma, Cancer 25:1384, 1970.
2. Willis, R.: Pathology of Tumors. Second Edition. Butterworth and Company, London, England, p. 756, 1953.
3. Sessions, D. G., et al.: Embryonal Rhabdomyosarcoma of Head and Neck in Children, Laryngoscope 83:890-897 (June) 1973.
4. Ragab, A. N., et al.: Rhabdomyosarcoma of Middle Ear: Four Year Survey, Cancer 30:648-650 (Sept.) 1972.
5. Horn, R. C. and Enterine, H. T.: Rhabdomyosarcoma: Clinicopathological Study and Classification of 39 Cases, Cancer 11:181, 1958.
6. Murray, J. E.; Matson, D.D.; Habal, M. B., and Geelhoed, G. W.: Regional Cranio-orbital Resection for Recurrent Tumors with Delayed Reconstruction, Surg, Gynec. & Obst. 134:437-447, 1972.
7. Inter Group Rhabdomyosarcoma Study. Role of Post-Operative and Combinations of Actinomycin, Vincristine, Cyclophosphenoids and Adriacycin in Childhood Rhabdomyosarcoma. Second Edition, 1974.
8. Habal, M. B. and Maniscalco, J. E.: Craniorbital Correction of Severe Facial Deformity: New Horizon in Corrective Surgery. J. Florida M.A. 63:345-346 (May) 1976.

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Treadmill Exercise Testing in the Private Practice Setting—1976

Franz H. Stewart Jr., M.D.

Abstract: After 50 years of exercise testing in this country, the treadmill is now emerging as the most accepted form of stress testing. It has a firm scientific foundation and safety record as it moves into the clinical arena and replaces the Master Two Step Test. Treadmill testing has become an important part of the current patient care armamentarium and has many valuable uses in the everyday practice of medicine and cardiology. The most common indications for treadmill testing in my experience have been cardiovascular screening and "fitness" determinations, evaluation of various chest pain subgroups, and rehabilitation progress in the postmyocardial infarction and postbypass patient. It has also been helpful in the evaluation of arrhythmias and various forms of "medical management."

Ischemic heart disease is the major health threat in this country and is responsible for the deaths of more than a quarter of a million people under 65 each year. More than half of those die suddenly without prior warning.[1] Now that improved medical (including risk factor modification) and surgical management is available, it becomes imperative to identify those with latent coronary artery disease. The history, physical, routine laboratory data and resting EKG are notoriously ineffective in this pursuit. Treadmill testing is the most reliable noninvasive technique for coronary artery disease screening and risk definition and becomes a natural extension of the standard "workup" of the middle-age male. This versatile method is also valuable in a number of other clinical situations primarily related to the prevention, diagnosis and management of coronary artery disease.

In the private practice of internal medicine and cardiology, I have personally supervised more than 450 treadmill stress tests during the last three and one-half years. Some of the tests were conducted on in-hospital patients, but the majority were done as outpatients. Approximately one third are my own patients and the remainder referred by other physicians in the community. The treadmill methodology has now totally replaced the Double Master Two Step Test in my practice. This is a discussion of the development and practical value of treadmill stress testing in a clinical environment and not a statistical analysis or support for a particular treadmill protocol.

Historical Highlights

Rotary type devices were used in Chinese and Greek cultures at least 2,000 years ago, notably in the area of construction. During the Roman Empire, various types of treadmill-like equipment were developed to power cranes for heavy lifting and as part of sophisticated water raising machines. English prisons during the mid-19th century frequently had a large treadmill device on which the previously in-

active and overcrowded prisoners could get needed exercise. However, this also was used as a common form of cruel punishment called "treading the wheel." Motivated by an interest in exposing such prison abuses, an English physiologist, Edward Smith, studied prisoners while they were on the "wheel." He measured a number of parameters such as heart rate, respiratory rate, and oxygen production before and at various intervals after exercising. His studies of the cardiopulmonary and metabolic responses to exercise on the treadmill represented the first systematic investigation of exercise physiology. This information was dormant for many years but was the forerunner of modern exercise testing.[2]

Exercise became a part of cardiac evaluation in 1929 when Master and Oppenheimer described their simple and clinically applicable Master Two Step Test.[3] This test was a measurement of cardiac capacity as determined by the blood pressure and heart rate response to traversing the two step apparatus a predetermined number of times within a defined time period. In its original form this exercise protocol did not involve the use of the electrocardiogram.

In 1928 Feil and Siegel published their observations of electrocardiographic recordings during a fortuitous episode of angina. The patient's resting tracing was normal but coincident with the development of pain ST depression was noted, which then returned to normal as the pain subsided.[4] This information established ST displacement as the electrocardiographic label for myocardial ischemia.

Since electrocardiograph recording during spontaneous angina was not practical, a provocative test was needed. Exercise became the physiologic stress for producing angina and concomitant ST depression. Wood and his co-workers at the University of Pennsylvania in 1931 reported data on patients exercised on a stairway. Some developed exercise-induced angina and ST changes[5] thereby demonstrating exercise electrocardiography to be a useful aid in cardiac diagnosis. During the subsequent decade, many investigators studied the electrocardiographic changes which resulted from exercise of various type and intensity. It was not until 1941 that Master published his modified test which then combined the standardized Two Step exercise protocol with exercise electrocardiography. This became the Master Two Step as we know it.[6]

Limitations of Master Two Step

It gradually became apparent that there were a number of shortcomings to the Master Two Step Test. The assumption that the workload should vary according to the weight of the individual was found to be invalid. The exercise prescribed in the Master protocol puts a higher work burden on lighter weight individuals.[7] In addition the workload of the Master Test and that of the augmented forms such as the present most popular one, the Double Master, is arbitrary.[8] There is no physiologic or pathologic magic for the prescribed number of steps or duration of performance.

The variability in the relative energy requirement needed to accomplish the prescribed trips results in a wide range of pulse levels attained. One study of the Double Two Step Test revealed heart rates varying from 100 to near 200.[9] Athletic types are greatly understressed while some poorly conditioned people or patients with severe heart disease are sometimes over exercised. It is based on a precalculated workload rather than a performance dictated one and is therefore not an effective method of determining levels of cardiovascular fitness.

Since the heart rate is often insufficiently elevated, it is not surprising that the Double Master has a poor sensitivity for uncovering latent coronary artery disease. The more vigorous treadmill tests are two to three times as sensitive as the Double Master.[10] Even in patients with symptomatic angiographically demonstrated coronary artery disease, Mason found only 56% had positive Double Master Tests.[11]

The Double Master is a "blind" test in that the electrocardiographic responses during exercise are not recorded. Experience with monitored graded testing has revealed a number of patients with ischemic ST-T changes during exercise but which disappear so quickly after exercise that they would be missed by the classic Master Two Step. The Master Two Step has served well for over 40 years and its simplicity, low cost and, "well-worn" familiarity are largely responsible for its continued use. With the advent of high level graded exercise testing, the limitations of the Master Test have been largely ameliorated.

Graded High Level Exercise Procedures

Exercise performed to accomplish progressive increments of work under closely monitored conditions has become the accepted stress testing method. The heart rate is directly related to the energy expended and this becomes a practical and useful physiologic indicator.[12] In contrast to the predetermined workload of the Master exercise stress test, the multistage tests are "open-ended." The

patient continues to exercise at stages of increasing intensity until a desired heart rate is obtained. The predicted maximum heart rate, or a percentage thereof, becomes the target goal for the graded stress test. A number of different methods of applying the workload have been utilized. The graded step test procedure described by the Tennessee Heart Association[13] and the bicycle ergometer are two such procedures; however, the treadmill has become the most popular graded high level exercise stress procedure in this country.

The treadmill is a practical and effective way of providing the workload stages necessary for a graded exercise test. A number of different treadmill protocols are available that utilize various speed and grade combinations to provide increasing energy requirements until test goals are reached. The various high level exercise treadmill test results are easily interrelated by nomograms and charts comparing pulse rate, time on the treadmill, and work performed.[14,15] Most investigators continue the test to the predicted maximal heart rate or a high percentage thereof.

In my private practice I have found it helpful to use a variety of treadmill formats depending on the purpose of the test and other factors, such as the age, sex, and athletic ability of the individual. The overall medical condition also plays a role in the choosing of the appropriate protocol. When testing elderly or uncoordinated individuals, I use a lower level energy requirement with more gradual increase in workloads. For example, the Naughton test utilizes a constant slow walking speed of 2 mph with increasing treadmill elevations at three minute intervals. On the other hand, in the majority of tests a higher level more rapidly increasing workload is feasible. The Balke Test is another constant speed treadmill test but one that requires some agility because of the 3.4 mph brisk walk from the start. The Bruce protocol, which offers a combination of increasing treadmill speed and grade, has been used in the majority of my tests. It requires approximately one half the treadmill time as does the Balk test to reach a particular level of oxygen consumption.

The MET is a useful term in exercise physiology and refers to the resting energy requirement. It is equivalent to a basal metabolic rate and all activities can be expressed in multiples thereof. In contrast to previous measurements of energy expenditure, such as the calorie and oxygen consumption, the MET is not dependent on weight. Desk work or driving a car requires 1.5-2 METS; scrubbing floors, bowling, or using a bedpan 3-4 METS, and heavy labor, tennis or a Double Master Test 5-8 METS. Vigorous sports utilize up to 12 or more METS.[16]

Treadmill testing is a dynamic procedure and it is often the changing pattern on the monitor or the clinical appearance of the patient that becomes important. The gradual and sometimes subtle ST segment changes or the increasing or decreasing evidence of ventricular irritability, when seen in their development, have more meaning than static recorded strips seen later. Clinical observations such as an unsteady gait, mental status alterations, skin changes, or the development of a murmur or gallop are important in the conduct and interpretation of the test. Abnormal blood pressure responses not uncommonly interdict the test procedure.

The close physician participation and observation results in a number of beneficial spinoffs. The continuous output of data during this "ongoing" test helps one to understand the gradation of response. There are all degrees of coronary artery obstruction and alterations in coronary blood flow and, as would be expected, the results of stress testing do not have a precise cutoff point but are part of a continuum. The absolute Yin Yang interpretation of results being either "positive" or "negative" is a pathophysiologic myth. The quantification of results greatly increases the value of the test as an aid to patient management. A 3 mm downsloping ST segment occurring early in exercise obviously has much greater significance than a 1½ mm upsloping ST depression occurring at maximal exercise.

The treadmill test is a unique experience shared by the patient and his physician. In addition to the important objective information obtained, the mutual interchange results in an increased communication and camaraderie between the patient and physician. Enchanced motivation for indicated changes in lifestyle is a natural result. The ability of the patient to exercise and his response to exercise is best understood by actual observation. An appropriate and feasible exercise prescription can then be formulated. The majority of patients enjoy the procedure and look forward to repeating it at a later date.

Safety of Exercise Testing

A review of 170,000 stress tests done at 73 centers revealed a death rate of approximately 1 per 10,000. The mortality was no more in the vigorous tests than with the Master protocol.[17] Ellestad has had three deaths in over 10,000 treadmill studies and none in the most recent 4,000.

Two of the three deaths occurred at low levels of exercise, less than that which would have been the target energy requirement of the routine Double Master.[18] Bruce and his associates have done over 15,000 maximum treadmill studies with no fatalities. These excellent safety records are a result of the fact that the procedures are supervised by physicians well trained in exercise physiology and clinical cardiology. Overzealous and untrained persons might have a very different experience. Constant physician monitoring is critical to the safety of the treadmill test, which is often altered or stopped before the physiologic goals are reached.

My experience also substantiates the safety of treadmill testing in the private practice setting. In the 450 treadmill procedures that I have conducted over the last three and one-half years, there has been no mortality or significant morbidity. Several different arrhythmias have occurred including multiple PVC's, ventricular bigeminy, short runs of ventricular tachycardia, multiple PAC's and one episode of transient atrial fibrillation. In another test, a bout of paroxysmal atrial tachycardia occurred and was immediately terminated by carotid massage. No other treatment, except for stopping the exercise, has been required.

The treadmill tests can be safely conducted in a private office, outpatient cardiac testing and rehabilitation unit, or within a hospital. Regardless of where it is done, appropriate emergency equipment must be readily available along with paramedical personnel well trained in resuscitation techniques. I believe that a nurse or technician with coronary care or cardiovascular lab experience is desirable. The screening and physical fitness tests can be accomplished by the appropriately trained family practitioner or general internist, but the chest pain and rhythm disturbance evaluation tests and certainly the cardiac rehabilitation tests should be supervised by a cardiologist. Every patient should have at least a cardiovascular history and physical and a resting EKG prior to the test. These can be accomplished by the referring physician, but carefully reviewed, and if necessary updated by the one conducting the test. An appropriate consent form must be signed in advance.

Predictive Accuracy of Treadmill Testing

From an epidemiologic standpoint, the predictability of the treadmill stress test in relationship to subsequent risk of coronary event (angina, myocardial infarction, or sudden death) continues to be reaffirmed. Particularly impressive was a recently reported follow-up study of 2,700 patients, both with and without known coronary disease, who had maximum treadmill stress tests. At the end of four years, those with positive tests had seven times the incidence of new coronary events as did the negative responders. This increased risk continued and after eight years 76% of the positive treadmill group had manifest a coronary event, an incidence of almost 10% per year.[19]

While the value of treadmill testing in risk factor analysis in large populations is clear, its accuracy in predicting angiographic findings in the individual depends on the type of patient being tested and a number of semiquantitative measurements of treadmill responses. In patients with typical angina, the correlation is good with a sensitivity (true positives) of 65-85%, and an average specificity (true negatives) of 90%.[11,20-22] When asymptomatic patients are studied, the correlation with angiography is considerably less.[23,24] The incidence of false positives is greatly increased if women are included.

There are a number of well documented causes of false positive stress tests, including electrolyte abnormalities, conduction disturbances, hyperventilation, drugs, and noncoronary artery disease induced left ventricular dysfunction, e.g., hypertension, myocardiopathy, or valvular disease.

Frequently the lack of correlation is a reflection of the different measurements of the two techniques rather than a true "false positive." The stress test does not directly measure the anatomic obstruction as does coronary arteriography, and likewise the coronary artery dye studies do not measure functional capacity. For example, some asymptomatic patients with old infarctions without significant "pump" dysfunction or other areas of "ischemic" myocardium have normal maximum treadmill stress tests. In this type of patient population treadmill studies would be expected to have a low sensitivity. The different information obtained from these two techniques is often required for formulation of appropriate preventive and therapeutic recommendations.

In addition to patient selection, there are several semiquantitative factors in the treadmill results that significantly affect the reliability of the treadmill stress test. The degree of ST depression has a linear correlation with risk. A long term follow-up of 3,325 men, who had had modified Double Master Tests done as part of life insurance applications since 1949, demonstrated that even minimal, i.e. less than 0.5 mm, ST depression, indicated some increased risk, and that the greater the depression

the poorer the prognosis.[25] A study using the Bruce treadmill protocol showed that the greater the ST depression, the more arteries significantly involved. ST depression of 2 mm or more was associated with significant obstructive disease in 100% of patients — 75% of this group having severe triple vessel disease.[21]

As would be expected, ischemic ST depression occurring at a low level of exercise is a more significant indicator of coronary artery disease than similar ST depression occurring later at higher levels of energy expenditure. Ellestad's large follow-up series revealed a risk of 15% per year in those with positive tests at 4 METS or less and only 4% per year in those who manifest ischemic changes at 8 METS.[19] The duration of ischemic changes also influences the significance of the results. When they persist more than eight minutes after cessation of exercise, there is a 90% incidence of double or triple vessel disease.[26]

Indications for Treadmill Testing

Asymptomatic Screening and Exercise Prescription

The treadmill test is the most accurate noninvasive method of identifying latent coronary artery disease. By helping to single out those at increased risk, before symptoms appear, appropriate preventive and therapeutic measures can be taken to hopefully reduce the morbidity and mortality. Treadmill testing also gives objective baseline physiologic information for evaluating subsequent symptom development and regimen changes. Male patients should have a treadmill test at age 35 and at 3-4 year intervals thereafter. A change in clinical status or the starting of a vigorous exercise program might warrant earlier or more frequent testing. Asymptomatic women under the age of 50 have a particularly high percentage of false positive treadmill tests, and the routine screening of this group is probably not warranted at this time, although a negative test does have reliability.

In the asymptomatic patient, the treadmill results should be viewed as important relative risk factor information but not as unequivocal evidence for or against coronary artery disease. The quantitative treadmill results are added to the other clinical information to form a data base from which decisions regarding further tests such as an angiography can best be made.

Treadmill testing is a prerequisite for the determination of "cardiovascular fitness" and the formulation of an exercise prescription. Many of the occasional misfortunes of the old jogging programs can now be avoided by weeding out those who should not be exercising or should be exercising at lower levels. A 74-year-old gentleman with rare angina inquired of us: "Is it safe for me to continue my nine holes of golf twice a week? How about cross country skiing with my grandchildren at Aspen?" At the other end of the physical fitness evaluation spectrum, a middle-age marathon runner is tested at his request (and probable ego fortification) regularly to objectively define his relative cardiovascular efficiency as well as the safety of his vigorous avocation. The exercise prescription is a direct translation from the MET performance on the treadmill to an appropriate MET defined exercise program. A 7-8 MET work level on the treadmill, e.g., through State II of the Bruce Protocol—2.5 mph at 12% grade, represents an energy expenditure similar to jogging at 5 mph, bicycling at 12 mph, or playing paddleball. Ten METS are required to run at 6 mph while 15 METS are needed to run at the rapid speed of 10 mph.[16] The pulse rate is used as the monitor of the particular exercise intensity.

Evaluation of Chest Pain

The evaluation of "typical" and "atypical" chest pain has been another common indication for treadmill testing. Removing an unwarranted diagnosis of "cardiac pain," with its concomitant restrictions, is equally as important as establishing the diagnosis of coronary artery disease in another patient with chest pain. Most patients with typical angina and positive treadmill test, who had angiography, showed significant coronary artery obstructive disease. A number of patients had angina and positive stress tests but did not have angiography, either because they refused or they were thought not to be surgical candidates. The observation of angina during a treadmill test is a vivid experience and leaves little doubt as to the diagnosis.

A 50-year-old small businessman with atypical chest pain had a submaximal treadmill test to a level of 10 METS with an "intermediate" exercise electrocardiographic response (Fig. 1). This type of upsloping ST segment with ST depression persisting to 0.08 seconds from the "J" point has a predictive value similar to the flat ST segment[27] and is to be distinguished from pure "J" depression which is not an indication of a positive test. This is still much less accurate than the classic ischemic down-sloping configuration.[26]

One year later the same patient was retested because of the onset of angina and developed 2½ mm down-sloping ST depression and chest pain very

early in the test when functioning at only 4 METS. As would be expected by this strongly positive response, angiography revealed severe triple vessel disease. Another stress test nine months postbypass surgery showed a normal response to a level of 10 METS.

The atypical chest pain population has a treadmill predictability similar to the asymptomatic group. On several occasions a noncardiac etiology of an undiagnosed chest pain syndrome, such as a musculoskeletal disorder or pleuritic pain, has become obvious during the treadmill test. Two of our patients with atypical chest pain (one male and one female, both in their 30s) had "false positive" treadmill studies caused by hyperventilation. These changes are very rarely a result of coronary artery disease.[28, 29]

Evaluation of Therapeutic Regimen

The assessment of the functional cardiac impairment by treadmill testing is very important in evaluating the effectiveness of a treatment regimen in coronary artery disease whether it be exercise prescription, drug therapy or coronary vein bypass surgery. In the postmyocardial infarction patient, the treadmill can be used in the assessment of the patient's status and in the recommendation of appropriate activity. These tests can help with earlier ambulation and rehabilitation of these patients. I sometimes have such patients merely walk on the treadmill at a zero grade and slow speed of one to two miles an hour for a few minutes with a low level pulse target rate. Accomplishing this greatly increases the confidence of the patient—and that of

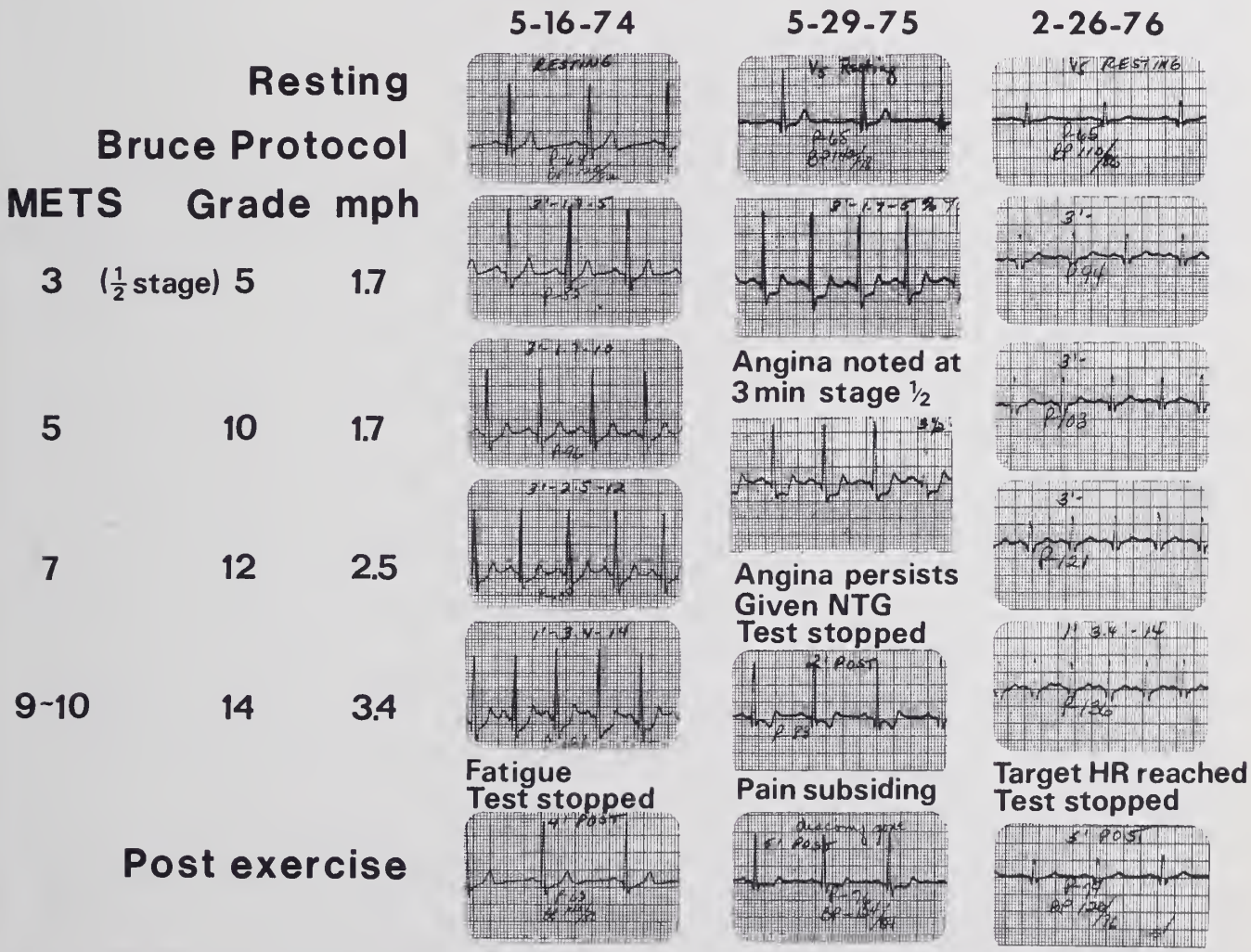


Fig. 1.—EKG strips from serial treadmill studies on a patient using the Bruce protocol of increasing grade and speed at 3 minute intervals. An "intermediate" response was found in 1974 when the patient was evaluated for atypical chest pain. One year later when typical angina developed a strongly ischemic response resulted. In 1976, nine months after bypass surgery, he had a normal submaximal stress test.

his physician—that progress is being made and that perhaps more strenuous activity can be prescribed. If there is any evidence of myocardial irritability or ischemic changes, the particular activity can be temporarily deleted or curtailed.

Periodic treadmill studies are also used to help guide the postcoronary artery bypass surgery patient in regard to his activity and exercise rehabilitation program. A negative test at various intervals post-surgery is strong evidence for patency of the grafts. One patient changed from negative at three months to positive at nine months and was found to have closure of two of three grafts on angiography.

The treadmill is also very useful in the evaluation of "medical management." Increasing exercise tolerance as determined by the treadmill test is good evidence for the efficacy of a therapeutic program. The coronary vasodilators and beta blockers are very unpredictable in their action, and measurements of their benefit were previously difficult because of the major subjective component to angina and the treatment thereof. The treadmill offers an objective way to determine their benefit, i.e., is the patient able to do more physical work prior to the onset of angina? These medications reduce myocardial oxygen demand rather than increase supply. The heart rate-blood pressure product at which the angina occurs is not altered by these medications but angina appears after more energy expenditure.[30]

Other Uses of the Treadmill

The whole gamut of rhythm and conduction disturbances may be precipitated by exercise, and exercise can sometimes abolish rhythm abnormalities present at rest. Persistent atrial arrhythmias are rare. The significance of PVC's associated with treadmill testing remains uncertain, and they do not by themselves warrant the label of a positive test.[31] It is not uncommon for the arrhythmia to manifest itself in the immediate post-exercise period. Ventricular arrhythmias are ominous signs in association with advanced coronary artery disease. Since these arrhythmias may be present only during exercise, the treadmill test may help discover those patients who are at particularly high risk.[32] The treadmill is also useful in the evaluation of the success of anti-arrhythmic therapy.

The treadmill has been very helpful in work evaluations of various types and help answer the question, "Is the patient able to work and at what capacity?" Bruce correlated the energy requirements of various treadmill procedures with the New York Heart Association functional classification. Class II patients can usually function at a level of 5 or 6 METS while the more impaired Class III patients are limited to 4 or less METS. The energy requirement for the workload accomplished on the treadmill can be translated into physiologically defined job descriptions. A Class III patient could not be expected to work as a painter or welder or participate in large machine assembly. Snow shoveling, ditch digging and some work by the handicapped with self-help devices require considerable work, at 8 METS or more.[16]

The treadmill test is no longer just an experimental methodology but is now an accepted clinical tool. Extensive data is now available that support its usefulness and practicality. Many large corporations now include this as part of their annual executive physical examinations and various organizations are requiring it for health evaluations, work determinations, and estimates of insurability. It is not uncommon for a patient to ask for a treadmill test. Despite its increasing use, the treadmill is still only scratching the surface of its potential value in private practice.

References

1. Stamler, J.: Acute Myocardial Infarction Progress in Primary Preventions, Br. Heart J. 33: (suppl.) 145-164, 1971.
2. Adams, C.: Introduction. Symposium on Exercise and the Heart, Am. J. Cardiol. 30:713-715, 1972.
3. Master, A. and Oppenheimer, E.: A Simple Exercise Tolerance Test for Circulatory Efficiency with the Standard Tables for Normal Individuals, Am. J. M. Sci. 177:223-243, 1929.
4. Feil, H. and Siegel, M.: Electrocardiographic Changes During Attacks of Angina Pectoris, Am. J. M. Sci. 175:255-260, 1928.
5. Wood, F. and Wolfert, C.: Angina Pectoris, Arch. Int. Med. 47: 339-365, 1931.
6. Master, A.: Exercise and Stress Testing. The Master Two-Step Historical Highlights and Current Concepts, J.S. Car. M. A. 12 Supplement 1:12-19, 1969.
7. Dentry, J.: Exercise Testing and Training in Coronary Heart Disease, Baltimore, The Williams and Wilkins Co., p. 21, 1973.
8. Spodick, D.: Editorial: Ischemic Responses Predictive of Coronary Death, Master vs. Physiologic Stress Tests, JAMA 234:745, 1975.
9. Sheffield, L.; Holt, J., and Reeves, T.: Exercise Graded by Heart Rate in Electrocardiographic Testing for Angina Pectoris, Circ. 32:622-629, 1965.
10. Froelich, V.; Thompson, A.; Longo, M.; Triebwasser, J., and Lancaster, M.: Value of Exercise Testing for Screening Asymptomatic Men for Latent Coronary Artery Disease, Prog. Cardiovas. Dis. 18:265-276, 1976.
11. Mason, R.; Likar, I.; Biern, R., and Ross, R.: Multiple-lead Exercise Electrocardiography. Experience in 107 Normal Subjects and 67 Patients with Angina Pectoris and Comparison with Coronary Cinearteriography in 84 Patients, Circ. 36:517-525, 1967.
12. Wyndham, C.; Strydom, N.; Martiz, J.; Morrison, J.; Peter, J. and Potgieter, Z: Maximum Oxygen Intake and Maximal Heart Rate During Strenuous Work, J. Appl. Physio. 14:927-936, 1959.
13. Physicians' Handbook for Evaluation of Cardiovascular and Physical Fitness, Second Edition. Tenn. Heart Assoc., 1972.
14. Fox, S.; Naughton, J. and Haskell, W.: Physical Activity and the Prevention of Coronary Heart Disease, Ann. Clin. Res. 3:404-432, 1971.
15. Pollock, M.; Bohannon, R., and Cooper, K.: A Comparative Analysis of Four Protocols for Maximal Treadmill Stress Testing. Am. Heart J. 92:39-46, 1976.
16. Fox, S.; Naughton, J., and Gorman, P.: Potential for Prevention of Coronary Heart Disease and Possible Mechanisms. Modern Concepts Cardiovascular Disease, Vol. 41:17-20, April, 1972.
17. Rochmiss, P. and Blackburn, H. Exercise Tests. A Survey of Procedures, Safety and Litigation Experience in Approximately 170,000 Tests, JAMA 217:1061-1066, 1971.
18. Ellestad, M.: Stress Testing. Principles and Practice, Philadelphia, F. A. Davis Company. P. 23, 1975.
19. Ellestad, M. and Wan, M.: Predicative Implications of Stress Testing. Follow-up of 2700 Subjects After Maximum Treadmill Stress Testing, Circ. 51:363-369, 1975.

20. McHenry, P.; Phillips, J. and Knowbel, S.: Correlation of Computer-quantitated Treadmill Exercise Electrocardiogram with Arteriographic Location of Coronary Artery Disease, Am. J. Cardiol. 30:747-752, 1972.
21. Bartel, A.; Behar, V.; Peter, R.; Orgain, B., and Kong, Y.: Graded Exercise Stress Tests in Angiographically Documented Coronary Artery Disease, Circ. 49:348-356, 1974.
22. Martin, C. and McConahan, D.: Maximum Treadmill Exercise Electrocardiography: Correlations with Coronary Arteriography and Cardiac Hemodynamics, Circ. 46:956-960, 1972.
23. Froelicher, V.; Yanowitz, F.; Thompson, A., and Lancaster, M.: The Correlation of Coronary Angiography and the Electrocardiographic Response to Maximal Treadmill Testing in 76 Asymptomatic Men, Circ. 48:597-604, 1973.
24. Borer, J.; Brensike, J.; Redwood, D.; Itscoitz, S.; Passamani, E.; Stone, N.; Richardson, J.; Levy, R. and Epstein, S.: Limitations of the Electrocardiographic Response to Exercise in Predicting Coronary Artery Disease, New England J. Med. 293:367-372, 1975.
25. Robb, G. and Seltzer, F.: Appraisal of the Double Two-Step Exercise Test. A Long Term Follow-up Study of 3,325 Men, JAMA 234:722-727, 1975.
26. Goldschlager, N.; Selzer, A., and Cohn K.: Treadmill Stress Tests as Indicators of Presence and Severity of Coronary Artery Disease, Ann. Int. Med. 85:277-286, 1976.
27. Stuart, R. Jr. and Ellestad, M.: Upsloping ST Segments in Exercise Stress Testing—Six Year Follow-up Study of 438 Patients and Correlation with 248 Angiograms, Am. J. Cardiol. 37:19-22, 1976.
28. Jacobs, W.; Battle, W., and Ronan, Jr.: False-Positive ST-T Wave Changes Secondary to Hyperventilation and Exercise—A Cine angiographic Correlation, Ann. Int. Med. 81:479-482 1974.
29. Lary, D. and Goldschlager, N.: Electrocardiographic Changes During Hyperventilation Resembling Myocardial Ischemia in Patients with Normal Coronary Arteriograms, Am. Heart J. 83:383-390, 1974.
30. DuBusk, R.: The Value of Exercise Stress Testing, JAMA. 232: 956-958, 1975.
31. Faris, J.; McHenry, P.; Jordan, J., and Morris, S.: Prevalence and Reproducibility of Exercise-induced Ventricular Arrhythmias During Maximal Exercise Testing in Normal Men, Am. J. Cardiol. 37:617-621. 1976.
32. DeMaria, A.; Zakauddin, V.; Amersterdam, E.; Mason, D., and Massumi, R.: Disturbances of Cardiac Rhythm and Conduction Induced by Exercise, Am. J. Cardiol. 33:732-736, 1974.

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Florida Swine Flu Update

The initiation of the National Influenza Immunization Program was delayed for several crucial weeks as Congress debated the issue of liability protection to vaccine manufacturers as well as other participants in the program. With the passage of favorable legislation the vaccine was released to the states; Florida receiving its first shipments in late September. Within a month almost 2.6 million doses (0.5cc per dose) of Bivalent and Monovalent vaccine had been received. The two types of vaccine were developed for different target populations. The Bivalent vaccine, which contains the swine flu virus and the A/Victoria virus, is recommended for persons 65 years of age or older and for those individuals with chronic diseases such as asthma or heart disease. The remainder of the populace, 18 years of age or older, are to receive the monovalent vaccine containing only swine flu antigen. Recommendations concerning vaccination of adolescents are pending and are expected to be released sometime in November.

During the first month of the program, 28% of the vaccine received was administered to 740,000 Floridians. This equates to approximately 12% of the total target population of six million. Florida's accomplishment ranks favorably with that of other states, especially for states with target populations in excess of one million. Florida ranked fourth among these.

Initial public and medical acceptance of the program has been good. The response to requests for volunteers to assist with the program is excellent. However, reports of deaths in Pennsylvania, Michigan, Florida and other states, of persons who had recently been vaccinated, diminished acceptance in most counties. Revitalization of the program followed the determination that the deaths were not directly related to the vaccine, and by the end of October vaccine was being administered to 275,000 Floridians per week.

All reports of adverse reactions in Florida are being carefully evaluated. Through the end of October, a total of eight people had died in the state within 48 hours of receiving vaccine. All of these people had histories of cardiac disease and only one (age 63) was less than 65 years of age. Five other persons had been hospitalized for observation after being vaccinated, and a total of 29 persons had been seen at various outpatient facilities or emergency rooms.

The program in Florida is not without weaknesses. The level of vaccination per week must be doubled to a minimum of 450-500,000 individuals. Immunization at this rate would result in about 70% of the target population being vaccinated prior to the Christmas holidays, and importantly, would mean that an even higher percentage of the high risk population (probably 75-80%) would have received Bivalent vaccine by that time.

A sustained effort by both the public and private health delivery sectors is mandated.—E. Charlton Prather, M.D., Director, Florida Health Program Office, Tallahassee.

Papular Urticaria

Robert H. Cohan, M.D. and Gary Griffin, M.D.

Abstract: Papular urticaria is a commonly diagnosed problem of childhood associated with a high incidence of discomfort to the affected patient and their family and resists much of the therapeutic armamentarium the physician has to offer.

Etiology, differential diagnosis and therapy of this disorder are discussed.

Papular urticaria, also known as insect prurigo, strophulus, and lichen urticatus, commonly occurs among children two to seven years of age. Incidence reaches a peak in the warmer months corresponding with activity of the biting insect whether mosquitoes, gnats, fleas, bedbugs or lice. More often affected are the lower socioeconomic groups and the population of certain geographic areas.[1-5] Usually the condition does not occur until the child has experienced two summer seasons, and after age seven years immunity may be expected. Only one family member may be affected.

The differential diagnosis of lesions includes prurigo mitis, scabies and other bullous childhood diseases such as dermatitis herpetiformis, drug eruptions, impetigo, and common urticaria.

Prurigo mitis may result from long-standing papular urticaria.[6] Scabies has a predilection for hands, wrists, interdigital spaces, and perineal and periumbilical areas. It consistently presents with nocturnal pruritis while papular urticaria has a moderate amount throughout the day. Infection of other family members and positive skin scrapings confirm scabies. Common urticaria is differentiated by bizarre, gyrate erythematous tracts and diffuse evanescent swelling generally without loss of epidermal integrity.

Thomas Bateman described papular urticaria in 1813.[7]

"There is scarcely any limit to the varieties of these papular affections, but I have observed one form which is so uniform in its character as to be entitled to notice here. It might be called lichen urticatus: its first appearance is in irregular, inflammed wheals, so closely resembling the spots excited by the bites of bugs or gnats as almost to deceive the observer. The inflammation, however, subsides in a day or two leaving small, elevated itching papules which become here and there confluent in small patches. The eruption is peculiar to children: it commences in some cases soon after birth and sometimes later and continues with great obstinacy for many months. Both wheals and papules are accompanied by intense itching which is exceedingly severe in the night, occasioning an almost total interruption of sleep and considerable loss of flesh."

Treatment

Treatment of papular urticaria is by no means as straightforward as the disease's description and often defies the physician's therapeutic armamentarium. Since the relationship to insect bites appears secure, the problem can be solved by hospitalization or having the patient visit a distant place, thus avoiding contact with the suspected offender.

The best and most desirable treatment is elimination of the source of the parasite. This may not always be possible. Antipruritic agents help for short periods, and hydroxyzine appears to be a desirable agent.[8] Insect repellants have only minimal effect. Gamma benzene hexachloride (Kwell) and crotamitor (Eurax) may be helpful initially because they leave a protective film against insects. The eruption may improve but rebounds when the lotions are discontinued.[9] Topical corticosteroids have limited efficacy and systemic steroids are too hazardous for application in a disease that, though prolonged, is generally self-limited and not life-threatening. Systemic antibiotics certainly have a place in treatment when lesions become secondarily infected.

In 1945 Eder described use of thiamine chloride in the prevention and therapy of flea bites.[10] In 1973 Ruiz-Maldonado reported his experience with

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it in Mexico city among 130 patients with insect prurigo.[11] Fifty did not return for follow-up. He administered 300 mg thiamine chloride per day divided in three doses. After one month 90% of the 100 patients were better or free of symptoms; 7% showed no change, and 3% were worse. There were no apparent significant side effects.

Ruiz-Maldonado's report does not speculate upon the mechanism of action of thiamine chloride but it is generally believed that thiamine causes the patient's body to be repugnant to the insect. Use must still be considered anecdotal but it may have a place in selected patients.

Hyposensitization therapy with whole body extract of fleas has been used with varying degrees of success. McIvor and Cherney, using polyvalent flea antigen, reported clinical improvement in 115 of 128 hypersensitive patients with both subcutaneous and intradermal administration of the antigen.[12] This form of therapy generally has fallen into disfavor.

Discussion

Whether papular urticaria is truly an immunologic process or evoked by the direct effect of toxins from the offending insect or parts is unclear. In 1950 Blank and associates skin tested 30 patients to flea and bedbug antigens; 77% showed a 3 mm or greater reaction at 48 hours.[13] He applied the same test to 124 normal subjects with only two positive reactions at the end of 48 hours.

Shaffer et al expanded Blank's study in 1953 and biopsied an unknown number of patients' lesions as well as site of skin testing at 30 minutes and again at 48 hours.[14] He generalized that the 30 minute reaction skin test sites, true insect bites and early lesions of papular urticaria were very similar. The delayed skin test reaction and lesions of papular urticaria were similar. The acute reaction was characterized by interstitial edema, sparse to moderate infiltrate, and predominance of eosinophilia. Edema was not apt to be present but at times focal necrobiosis in the corium occurred instead. The old involuting papule was marked by relative sparseness of infiltrate and absence of eosinophils, the cellular collections being comprised solely of lymphocytes.

Histopathology occasionally is useful, especially when coupled with immunofluorescent studies, to sort out the possibility of pseudolymphomas, Mucha-Habermann disease, dermatitis herpetiformis and bullous disease of childhood.

Conclusion

Certainly more research is indicated in an effort to help unravel the problems of this common disorder. Designing good clinical trials and interpreting therapeutic success are difficult because of problems in determining the type of insect offender and the antigen involved, evaluating treatment results because much depends upon the patient's objective assessment of the therapy, and the self-limiting nature of the disease itself.

References

1. Shaffer, B.; Jacobson, C., and Pori, P.: Papular Urticaria: Its Relationship to Insect Allergy, Ann. Allergy 10:411-421, 1952.
2. Hewitt, M., et al: Pet Animal Infestations and Human Skin Lesions, Br. J. Derm. 85:215-224, 1971.
3. Rook and Frain-Bell, W.: Papular Urticaria, Arch. Dis. Child. 28:304, 1953.
4. McKeil, J. A. and West, A. S.: Nature and Causation of Insect Bite Reactions, Pediat. Clin. N. Amer. 8:795-816, 1961.
5. Wright, G. E.: Domestic Pet Infestation and Papular Urticaria, Practitioner 208:406-411, 1972.
6. Demis, D. J.; Dobson, R. L., and McGuire, J.: Clinical Dermatology, vol. III, Hagerstown, Md., Harper & Row, 1976.
7. Bateman, T.: Practical Synopsis of Cutaneous Diseases, 2nd Amer. Ed., James Crissy, No. 177 Chestnut St., Philadelphia, 1824.
8. Rhoades, R. B.; Leifer, K. N.; Cohan, R., and Wittig, H. J.: Suppression of Histamine-Induced Pruritus by Three Antihistaminic Drugs, J. Allergy Clin. Immunol. 55:180, 1975.
9. Massie, E. S.: Papular Urticaria: Etiology, Diagnosis and Management, Cutis 13:VI:980, 1974.
10. Eder, H. L.: Flea Bites: Prevention and Treatment with Thiamine Chloride, Arch. Pediat. 62:300, 1945.
11. Ruiz-Maldonado and Tamayo: Treatment of 100 Children with Papular Urticaria with Thiamine Chloride, Internat. J. Derm. 12:258-260, 1973.
12. McIvor, B. and Cherney, L. S.: Studies in Insect Bite Desensitization, Amer. J. Trop. Med. 21:493-497, 1941.
13. Blank, H.; Shaffer, U.; Spencer, M. C., and Marsh, W. C.: Papular Urticaria, Pediatrics 4:408-412, 1950.
14. Shaffer, B.; Jacobson, C., and Beerman, H.: Histopathologic Correlation of Lesions of Papular Urticaria and Positive Skin Test Reactions to Insect Antigens, Arch. Derm. Syph. 90:437-442, 1954.

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It glows best when the world around you
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"Approximately 95% of the [U.S.] children of ages 1-5 years had iron intakes below the standard"

U.S. Public Health Service (1974)

Where did that surprising statistic originate?

From the first survey designed to assess the nutritional status of the entire U.S. population. The conclusion above was the most striking result reported in the preliminary findings released in January 1974.

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Those conclusions were based on a sample of 10,126 people—a probability sample established by the U.S. Bureau of Census to reflect the country's total population, regardless of race or income.

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For whites and blacks, for both sexes, for both income levels, the mean intake of iron (as a percent of the standard) for the 1-5 year age group ranged from 60 to 69%. Typically, then, 95 children out of 100 have iron intakes that are only ⅔ of the standard.

Whose iron intake standard were they using?

The standard set by the Food and Nutrition Board of the National Academy of Sciences for this group.

Implication of all this?

That iron deficiency among preschoolers is anything but rare and signs like mental apathy, lethargy, irritability, behavior problems, may be telegraphing iron deficiency.

Suggesting iron supplementation?

Not necessarily. In many instances this situation can be corrected by proper diet and, obviously, this is the preferred route. When dietary improvement is not attainable, consider a supplement.

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Is this cited study generally available?

Yes, from the Office of Information, National Center for Health Statistics, 5600 Fishers Lane, Rockville, MD., 20852. Request "First Health and Nutrition Examination Survey", 1974, DHEW Pub. No. (HRA) 74-1219-1.

*B. Blackwell: The Drug Defaulter. *Clinical Pharmacology and Therapeutics* 13:841 (1972).

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Griffiths, L L., Brocklehurst, J.C., MacLean, R. et al *Diet in Old Age*, Brit. Med. J., 1:739, 1966



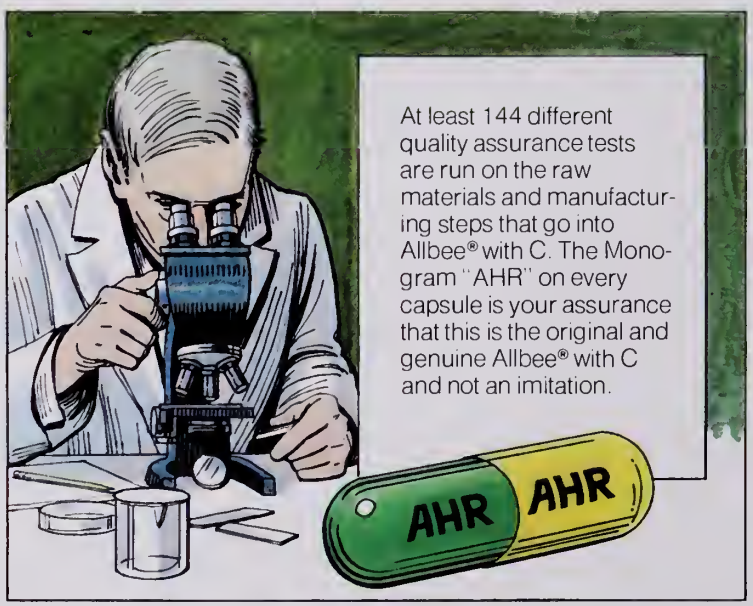
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SPECIAL ARTICLE

Commencement Address
University of Florida College of Medicine
May 30, 1976

A. Ashley Weech, M.D.

Ladies and Gentlemen of the Class of 1976:

Some years ago, James M. Landis, then Secretary of the Securities and Exchange Commission, delivered the graduation address at the commencement exercises of Princeton University. One sentence from his talk has lingered in my memory. Said Mr. Landis, "There is no teacher worthy of his salt, who has not been dismayed both by his own ability to portray a subject adequately and also by the unwillingness of his class to put forth the intellectual effort required to receive it." In their context these words were not spoken harshly, or in criticism they were uttered simply as an expression of fact. Nevertheless, they aroused in me a reaction of surprise. For if the statement applied to routine teaching where learning was the order of the day and where the impulse to acquire knowledge was regularly being stimulated by quizzes and examinations, how much more did it apply to the Commencement Address itself? To the 81 members of the graduating class of the College of Medicine of the University of Florida, I therefore say, "At ease." With confidence you may expect from me well-deserved congratulations on having completed a rigorous four years of medical education. You may expect that I shall speak of matters to challenge your behavior in the future. You may also expect that I shall dodge the direct answer to many legitimate questions. To be sure there are signs, which cannot be ignored, of a trend toward governmental control of all economic resources and of all private enterprise, but I dare not postulate that these things must be. To do so would deny belief in the inventive genius of man, a genius that has produced so recently television, aeroplanes that fly faster than the speed of sound, landings on the moon, and in medicine, the sulfonamide and antibiotic drugs. We have witnessed too often how predictions can be falsified by cataclysmic happenings in politics as well as in science and medicine. Before the address is finished, you will find that I have charged you with many cares and responsibilities to protect a noble profession. I shall have dared to ask much. It is right to expect much of you who before we adjourn will carry the name of doctor. Whatever may come, I urge you to listen not with intellectual effort but in comfortable relaxation. There will be no final examination.

You are graduating from a fine medical school in a country where, and at a time when, medicine has long since earned the right to be classed among the sciences. You have received instruction in anatomy, pathology, and microbiology. You have learned to recognize the morphological change wrought by disease and to identify and oftentimes destroy the microorganisms responsible for the alterations. Knowledge in these branches of medicine is, after all, not very old. Their introduction into the American curriculum around the turn of the century marks the beginning of an evolutionary process in this country. The craving for understanding, once started, has gone on and on. You have also been instructed in physiology, in biochemistry, and immunology. You have learned how radioactive isotopes can be used to unravel the mysteries of metabolism. You have witnessed the tearing apart of the basic unit of heredity, the gene. The question "What?" has largely been replaced by "How?". Those subjects in the curriculum which deal with function rather than structure are rightly being stressed. Energy metabolism, electrolyte balance, acid-base equilibrium, hyperventilation tetany, glucose tolerance, transaminase levels, and creatinine clearance have taken their place in daily medical parlance. Each brings to mind a disturbance of normal function and in each instance the study of function has strengthened the armaments of therapy.

It is unnecessary to stress the practical importance of such advances in knowledge. Of far greater significance is the effect on current medical thinking. The advances have not come from careful observation alone. Rather they are the reward of diligently pursued and usually imaginative research. The experimental method in medicine has expanded in power and resourcefulness to the point where empirical thinking has been forced to maintain a steady retreat from long-defended bastions. We have repeatedly witnessed examples of the truth implied in the saying, "A man can make the same mistake for forty years and call it experience." Not all empirical thinking has turned out to be fallacious but it has come to be "cricket" to challenge a dogmatic statement by asking for the evidence. This is the attitude of mind that has made medicine a science. This is the exciting field which you today are entering. I charge you to cherish the training you have received in the basic sciences, to guard yourselves constantly against the pitfalls of empiricism, and when puzzled, as you often will be, to let your mind rove along the broad paths of physiology in seeking an explanation.

It would be a fine thing if all of you could have graduate supervised experience in the methods of research. Such methods are fundamentally similar to those that should be used daily in the attempt to understand the symptoms or signs presented by patients. The method begins when an obscure symptom has aroused your CURIOSITY. In my manuscript I have written "curiosity" in capital letters because of its basic importance. More about this later! Curiosity leads to a hypothesis which in turn induces reflection and mental exploration of the possible corollaries. Let me stress this point in the process of reasoning for it is often neglected. Thinking about those things, which must also be true if the hypothesis is correct, not infrequently allows the hypothesis to be discarded at once. And, no money has been squandered in unnecessary laboratory tests. A hypothesis which cannot be abandoned is useful if it or one of the corollaries can be exposed to experimental tests. The testing may require the skill and imagination of a genius but again it may not involve more than looking for a sign which previously had been neglected. Repeated many times, the process is certain to have a chastening effect. Biological problems are complicated and rarely can be followed accurately through more than one serial deduction. But, the hypotheses are useful even when they turn out to be wrong. For, in that case they serve to discover at what point the reasoning went astray. Another hypothesis can be formulated and its consequences exposed to further tests of observation and experiment. The method in these terms is simple. Even without supervised training you can strive to make it a habit.

Perhaps you may counter, "These are the steps I have been taught to take and expect to take in reaching a diagnosis with most of my patients." I warn you it is not easy to move through a busy career and maintain a lively curiosity. Although nothing can make your professional lives more enjoyable than the habit of satisfying intellectual curiosity, the effort demands time, work, shortened hours for sleep and sometimes neglect of bewildered spouses or of economically-rewarding opportunities. The law of averages tells us there will be some among you unwilling or unable to pay the price. Such of you will never know the joy which might have been. Mechanisms of the human mind which protect against unhappiness will soon close in and in truth you will be no longer curious. You will dodge real issues with complacent statements, as "We must not go beyond the facts." To the rest of you I say, "Encourage your fancy to roam where it will. The danger line between fact and fancy will never be obscured when fancy is habitually encouraged to formulate tests whereby its truth can be examined."

A moment ago I stated that in my text, curiosity was spelled in capital letters. I cannot overestimate the importance for the future of maintaining a lively curiosity. It is the springboard from which all great discoveries and all brilliant diagnoses must initially take off. In my experience all children, and particularly boy children, are born with plenty of it. I especially recall my own son at kindergarten and first grade age: "Daddy, what is the candlepower of the sun?" and "Daddy, where did they put all of the dirt they dug out of the Panama Canal?" Such questions are evidence of an innate drive to know and understand. They must be answered seriously in the attempt to keep alive a God-given intellectual curiosity.

A couple of stories may serve to stress the obstacles to be encountered. A good many years ago when I was in charge of the children's out-patient division at Johns Hopkins, an intern called my attention to a child with mumps and an associated peripheral facial paralysis. I was fascinated by the association. The facial nerve always passes directly through an involved parotid gland. The question was, "Why is this the first instance I have ever seen? Why do not all patients with mumps parotid involvement exhibit facial paralysis?" I asked the intern to hold the child for half an hour in an isolation room while I went to the library in search of the

experience of others. At the end of 30 minutes, I returned carrying several informative tomes. I asked to see the patient again so that we could compare the findings in our patient with those previously described. I was crushed when the intern reported, "Dr. Weech, I was so busy this morning with other sick children, that I sent the patient home." That which was happening to this young doctor, again intruded into my thinking. Mechanisms of the human mind which protect against unhappiness had already closed in, and in truth he had killed his birthright and was now no longer curious.

A jewel of unexpected advice came from another source. This was years ago—just before ending a period of training at Hopkins under John Howland. I had applied for a coveted National Research Council Fellowship and was told to go to Boston and be interviewed by Lawrence J. Henderson. This is the Henderson known to all of you by his name being attached to the Henderson-Hasselbalch equation. I was young and somewhat awed by being in the presence of the mighty. The interview began with, "Well, young man, tell me about whatever research you have done so far." "Therein," I replied, "is the very reason for wanting a fellowship; it will give me the time to engage in research. I spend every morning reviewing the laboratory reports and x-ray films of patients seen the day before. In the afternoon I am occupied supervising the work of 19 other physicians who work in the out-patient division. In the evening I read all of the notes written on medical charts during the afternoon." Dr. Henderson interrupted, "Young man," said he, "would you like to know how you can carry on with your present job and still find time for research?" I replied that indeed I did want to know. His advice was simple, "Neglect some of your duties." These were words of consummate wisdom designed to save the mind and soul through liberation from some of the trivialities of daily routine. Will there ever be another way of cultivating curiosity? Neglecting duties means that colleagues will often have to take over. It will arouse resentment if the neglect springs from laziness. But, in my experience, when the neglect arises from zeal in the pursuit of knowledge, the colleagues do not resent the added work but rather are proud to have shared in a small way in the project of their peer.

The search for truth is always exciting. As a teacher who has personally experienced the exhilaration of investigation, I have been impelled to emphasize first this phase of your opportunity. But with it the vision of service is by no means complete. There will be challenging opportunities for resourcefulness as you practice the healing art. The application of knowledge to the needs of your patient may not be easy when the facilities to which you have been accustomed are no longer to be had. Here, indeed, is a chance for resourcefulness and here the courage to try is certain to bring excitement and sometimes a soul-satisfying reward.

Many years ago I went with a family physician to visit a baby on a farm in Alabama, many miles from the nearest town. The infant was literally skin and bones, too weak to cry above a whimper, too feeble to take nourishment from a bottle. But he was still alive and the dysentery which had sickened him two months earlier was no longer active. Hospital care was out of the question and I, only recently out of an intern's white clothes, could not imagine what could be done without the facilities provided by a modern institution. For the want of something better to say, I told the parents that if their baby was in a modern hospital he would be fed through a stomach tube to restore sufficient strength to allow him to take the bottle. The mother wept. But the father, a big man with toil-roughened hands, was thoughtful before he spoke. "Doctor," he said slowly, "when a fellow runs a farm he has to learn to do any sort of job that turns up. If you will show me how, I can give my baby the tube feedings." Catheter and syringe were obtained from a druggist in the nearest town, a formula of buttermilk, sugar, and starch was cooked in the farmhouse kitchen, and the father was shown how to pass the tube into the baby's stomach and how to inject the feeding. I cannot report that the child grew to full manhood and is alive and healthy today for I do not know, but I can tell you how I marveled to find him well along the road to recovery when I visited the farm again six weeks later.

The courage of that Alabama farmer contains a lesson for us all. Too often we hear the statement that this or that procedure, used in the hospital, is not applicable in the home. Foolish it would be indeed not to take advantage of institutional facilities when these are available and can serve the patient. But when they are not, and makeshift substitutes must be devised, the reward to him who has helped the patient will be a thousand times greater. You are to be congratulated on having chosen a career that can utilize the highest flights of the human intellect not only in the quest of knowledge but also in serving your fellow man.

Is this all? No, there is still more for you to do. It has been truthfully said that medicine is not just a science. The reasoning and experiment which I

have espoused, the exercise of ingenuity and skill in treating the patient can fulfill only a part of the responsibility which you must shoulder as doctors. The science of Aristotle must be blended with the philosophy of Plato. Comprehension of the biologic significance of essential vital processes must be accompanied by understanding of human yearning for a better way of life. It will require effort in the years ahead to lead a life that will meet the challenge. Cherish your contacts with thoughtful men in fields outside of medicine. Read regularly something from the classics. Visit your art museums and cultivate the opera and the symphony. The goal is nothing less than the molding of your characters and the process will bring with it tolerance and understanding.

Tolerance of annoying perversity, understanding of human frailty both in yourselves and in your patients, sympathy for suffering and fear—these must be the handmaidens of your science. The complex combination of dynamically interacting elements comprising the living body is fearful and wonderful to students of physics and chemistry and a constant challenge to those who pursue the expansion of medical science. But, the chemistry, the physics, and the sciences are not an end in themselves. They exist only to serve a living being who works and rests, weeps and rejoices, loves and is loved, marries and begets, grows old and dies, but somehow, through it all, strives to respect himself and to do his part to improve his neighbor's lot. Here is the humanitarian side of medicine. Patients are human; so also are doctors. Science and humanity cannot be cloven apart. Reason and emotion are rightly interjoined. You must know these things as you ply your art both with the goal of helping your patient and with a fervent determination not to transfer to him tenseness and worry which are products of your own insecurity.

Reassuring the soul is relatively easy when the illness is one for which a specific cure is at hand. But it is not so easy to bring comfort to parents whose only child has been stricken with a lethal disease. Honesty need not conflict with steadfast refusal to abandon all vestige of hope. Acts of kindness in the face of foolish whims may forever be remembered. Give generously of your time when patient, parents, or relatives can be encouraged to talk. While listening, be on the alert for possible signs of guilt. Parents often fear that something they did or failed to do is responsible for the illness, that some heritable trait has through them stricken their child. Only a physician can dispel these awful fears and the act is as much his job as the medicine he prescribes. Will you learn to reach a helping hand to such people in distress?

The closing phase of my address puts no premium on your place as doctors. It is merely a statement appropriate to the Bicentennial Year of the United States of America. It is a statement of pride in the significance of citizenship in a land of freedom which offers to all its people the chance to unite their efforts, a chance to demonstrate to themselves what they can do when aroused, the chance to multiply for their children the gifts that have been their birthright. It is a statement of pride in a country which understands the importance of free enterprise and which outshines all other nations in the ability to produce both in industry and on the farm. A great American, Wendell Wilkie, once said:

> "Only the productive can be strong,
> And only the strong can be free."

Over the many years of a busy medical life, it has been my luck to visit a number of less fortunate countries. I am speaking of China as it was in the late 1920's, of Puerto Rico as I knew it in the summer of 1941, of relatively recent trips to India, Egypt, Ethiopia, and Guatemala. In all of these areas dysentery, tuberculosis, and the nutritional disorders of hunger were rampant. Still vivid in memory is the recollection of being followed by groups of 20 to 30 children all with hands extended begging alms. Bedraggled children! Undernourished to a point approaching emaciation! Flies all over the face and eyes! Children too tired and too hungry to have the energy to brush the flies away! Small wonder that the group contains half a dozen who are blind, the blind being guided and pushed forward by a brother or sister to arouse sympathy; all with outstretched palms! Eyes destroyed by xerophthalmia and the keratomalacia of vitamin A deficiency aided and abetted by the virus of trachoma spread by the flies! It is sights like these that speak eloquently of the luxuries of home, that remind us not only of the freedom bequeathed to us by our forefathers but also of the beneficence of our farms and factories.

I dare to mention these matters to you who will soon be physicians because it is the mission of the profession to save life and relieve pain and suffering. You cannot, like the ostrich, bury your head in the sand and escape responsibility. Look across the native land of which we are so proud. Everywhere there is evidence of the power engendered by productivity. Let the significance of it pour into your

souls and generate the faith and the courage that impel men to make their dreams come true. Fill your cup with consciousness of the power until it runs over and, in spreading to those about you, drowns out the pestilence of worry and doubt. Let your courage reach out to embrace what your country shall mean to people in want throughout the world. Your faith and your compassion can bring to them a conviction of which Bryant cried, "Truth crushed to earth shall rise again." In so doing you will gain and disseminate understanding of a great people with a great mission. For them truth kept alive will need no resurrection. The ideals toward which we aspire, the deeds of which we dream, the way of life we wish to gain can all be attained through burning faith in the power, the destiny, the righteousness of free thinking people wherever they may be.

Dr. Weech, Department of Pediatrics, University of Florida College of Medicine, Gainesville 32610.

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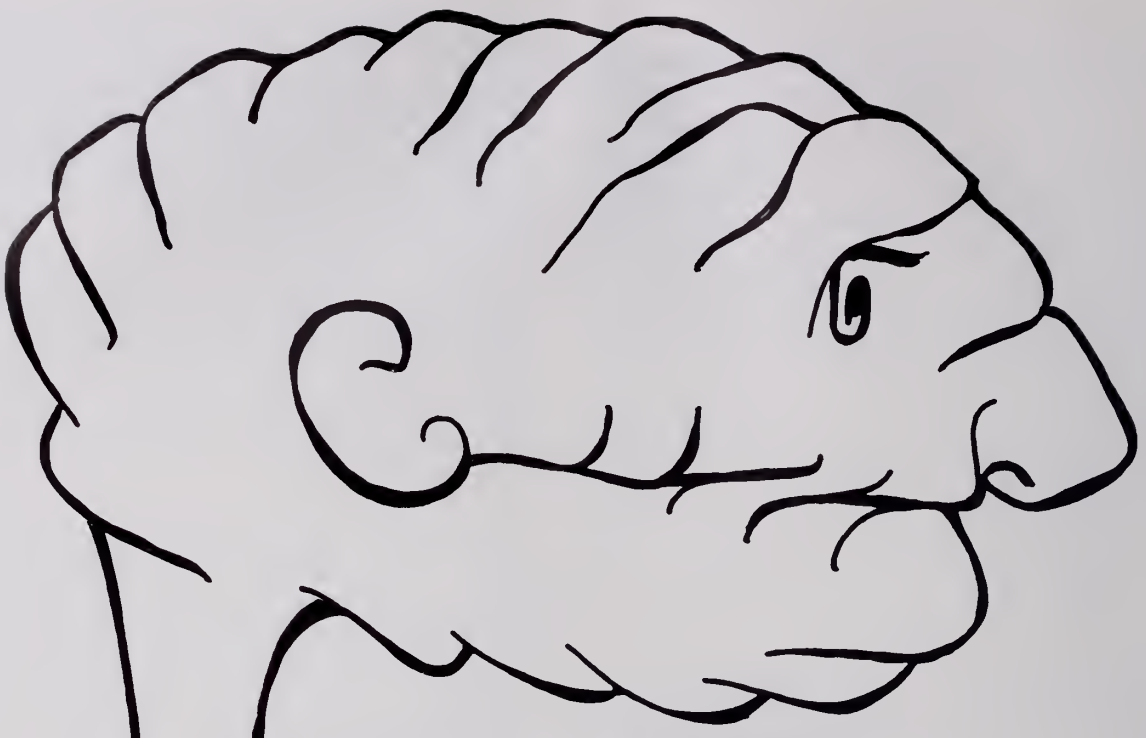
I am voices
giving orders,
calling for help,
whispering comfort;
I give life, save life, take life.

Night and day I seethe with activity
as doctors, nurses,
maintenance personnel
work like ants, singly or together
to aid people wracked in pain and despair,
coming continuously as the tides,
day in, day out;

I am the servant of God
who knows no race, no color, no creed.

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The Spectre At The Feast

Frank G. Slaughter, M.D.

In Charles Dickens' immortal classic for the Yuletide Season, Scrooge finds himself haunted by the ghost of Christmas past and emerges a better man for the experience. This Christmas the United States, and the world, finds itself in mortal fear of a visit from a ghost of quite a different kind, a virus that has lain dormant for some sixty years after killing more than 50,000 Americans and millions of others over the world. Dubbed Spanish Influenza during World War I, it has undergone, in a possible modern day recrudescence, the ignominy of being named "Swine Flu"—for which indignity one could hardly blame it for venting its spleen upon a thinly immunized public.

Pandemics are strange occurrences by any standards. More often than not, they are finally defeated by their own power to build immunity in such a large section of the population that they literally run out of flesh upon which to feed. So it was with the Black Plague of the Middle ages and, in Colonial times, with smallpox and yellow fever here in America. Nobody knows yet whether the ubiquitous Spanish Influenza of the 1918 period will reappear, or whether its immunological characteristics will exactly duplicate those which appeared last year in New Jersey. Hopefully, the forthright initiation of a national immunization campaign will create artificially the very situation that defeated it in the first instance, a vast reservoir of the immune; we can only wait and see.

Other possibly recurring plagues may not be controlled so easily, however, a soon to be published novel titled "The Black Death" depicts with chilling detail and scientific accuracy, how a sick ground squirrel in a California park starts a power train of death that turns the city of New York into a veritable jungle. Moreover, the perils of federal intervention are graphically depicted, when an inept bureaucracy panics with fear of a national epidemic and seizes control from a local public health organization that is already taking adequate measures to cope with the situation.

As one who lived through the 1918 epidemic as a boy and whose medical experience antedates the discovery of sulfanilamide, this writer can only hope, at Christmas 1976, the ghost of a virus from the past doesn't turn out to be yet another strain of the ubiquitous influenza virus seeking to test our medical skills. If it does, doctors are going to find themselves in the unaccustomed role of using a skill no longer taught in medical schools, that of comforting the sick and easing the passing of the dying, while facing an enemy against which we have no real weapons except our hearts and our hands, impotent though they be. It could be a sobering—and soul shaking—experience to thus wrestle with the spectre of Christmas past, and yet, it could remind us, as the ghost did Scrooge, of a quality of humanity in our calling that too many of us have, alas, forgotten.

Dr. Slaughter, Ortega Station, Jacksonville 32210.

"Doctoring"

Don D. Weiffenbach, M.D.

When I first began practicing medicine in rural north Florida a little over a decade ago, I had the good fortune to become associated with a learned and respected physician.* The most valuable knowledge he imparted to me was the fine art of "doctoring." Starting practice with an established physician had its pros and cons. Naturally it gave me a great deal of security but it was certainly frustrating to have patients repeatedly ask or imply "are you sure, Doctor?" or, "when will Dr. Landrum be back?" Of course, this I expected from his long time patients, but what particularly amazed me was his ability to command respect and confidence from a total stranger. His prescription was simple, but yet so subtle, it has taken me years to inpart develop and prescribe myself. The basic ingredients are:

(1) Listen; (2) Touch; and (3) Talk—and when they are gently mixed with concern you have "doctoring."

"Doctoring" is the universal prescription. Many diseases are self-limited, others, in spite of all our advances in medicine, remain incurable. Our purpose is to cure if possible, but if not, to alleviate our patient's suffering. To tell the patient that a shot of antibiotics will not help him is not enough, and to take a culture to see if he really does have "strep throat" or just a "virus" is adding insult to injury. If it is not strep throat it sure feels like one or worse to the patient. To tell the patient there is nothing we can do for him but to take aspirin is admitting our own ineptness in alleviating a rather common and simple malady in the wake of open heart surgery, antibiotics and cancer cures. The patient is sick! He should not be made to feel that you are too busy and need to get on with some other patient more important that you can specifically treat. He needs to be "doctored."

As noted, the universal prescription of doctoring has only three ingredients: (1) Listen, (2) Touch and (3) Talk; however, the proportions vary from case to case as does the manner in which they are mixed and dispensed.

The personality of all patients change when they are sick and most patients regress to a childish behavior and want to be "mothered" while others become suspicious and hostile. The trick is to **Listen** to the patient to determine what he wants to hear and then **Touch** him to let him know you are concerned and trying to help him. Now the talking requires a bit of salesmanship because you may not be able to tell him what he wants to hear, therefore, you have to gently mix it with listening, touching and dispense carefully.

The sorethroat, for example, is an especially perplexing problem. In all probability the patient will be feverish, aching and "sick all over" and has already taken aspirin, gargled and tried throat lozenges. In all probability you will take a culture, tell him to continue what he has been doing and charge him for an office visit. Now that is a feat which requires a bit of finesse if the patient is going to leave your office happy to pay your fee and confident he will get better. If you simply follow the accepted routine you have not "doctored" the patient, therefore, you have not given him the one prescription you have to offer and are not worthy of your charge. So it is of utmost importance that you **listen** to the patient and in doing so, you demonstrate some sympathy. Then by methodically **touching** and examining the patient you demonstrate that you are concerned enough to be exactly certain what his problem is. Don't just look at his throat but listen to his chest, palpate the abdomen, the whole bit. Then you must explain why it is so important that he continue with the same treatment and what to expect, and if anything other than the expected occurs to check with you or your nurse immediately. Once you have developed a workable technique the procedure can usually be accomplished in about 5-7 minutes. The patient is reassured and consequently feels better already and this makes you more satisfied with yourself and your treatment.

Now that's "doctoring," Doctor.

▶ Dr. Weiffenbach, P.O. Box 1947, Lake City 32055.

*Louis G. Landrum, Lake City

Dr. Weiffenbach states that this is his first attempt at writing and that he was inspired by an editorial in the July issue of the Journal entitled "Contributors to The Journal Make an Interesting Cluster," by one of our Associate Editors, Dr. E. Charlton Prather.

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MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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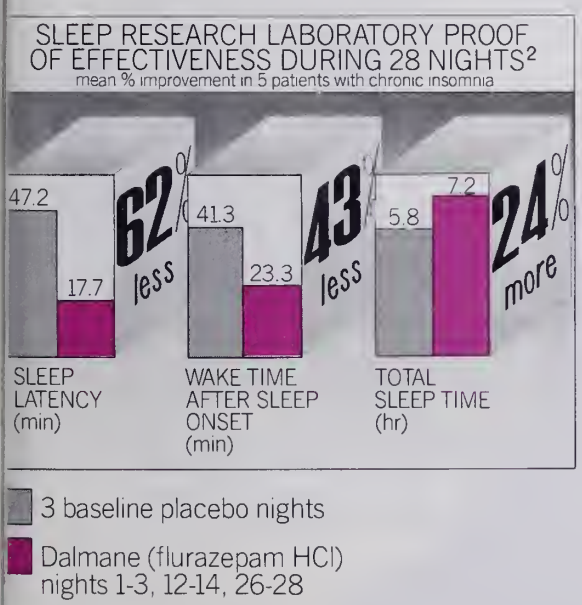
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For insomnia that is a chronic problem...

Only Dalmane (flurazepam HCl) offers sleep laboratory proof of effectiveness for as long as 28 nights

Continued relief of insomnia in patients with chronic insomnia

Since insomnia is often transient and intermittent, the prolonged administration of a hypnotic is generally not necessary or recommended. But when insomnia is a chronic or recurring problem, continued effectiveness is as important as initial effectiveness. Results of a recently published sleep research laboratory study[1] demonstrated that, while pentobarbital lost effectiveness within two weeks, Dalmane maintained effectiveness for 28 consecutive nights. Similar 28-night results with Dalmane, displayed below, were obtained by a second sleep research group.[2] In previous studies,[3] both chloral hydrate and glutethimide began to lose effectiveness after several nights, while Dalmane maintained effectiveness throughout the 14 medication nights. Whether the problem is difficulty falling asleep, staying asleep or sleeping long enough, consider these results when selecting a sleep medication.



Patient benefits include relative safety, infrequent morning "hang-over"

Dalmane is well tolerated, seldom causing morning drowsiness or grogginess.[4] No increase in dosage is required for continued effectiveness from night to night.[1-3] Should Dalmane be used repeatedly, periodic blood counts and liver and kidney function tests should be performed. The usual adult dose is 30 mg *h.s.*, but 15 mg may suffice for some patients and is recommended as a starting dose for the elderly and debilitated to help preclude oversedation, dizziness or ataxia.

Continued relief of insomnia: One more good reason to specify

Dalmane® (flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

whenever a hypnotic is needed

ROCHE

Please see following page for a summary of product information.

Objective proof: continued insomnia relief without increasing dosage...[1,2]

Dalmane® (flurazepam HCl) ℞ IV

Objectively proved in the sleep research laboratory...

during 28 consecutive nights of administration:

- ☐ **effectiveness with a single 30-mg *h.s.* dose, maintained**
- ☐ **rapid sleep induction, maintained**
- ☐ **sleep for 7 to 8 hours, on average, maintained**
- ☐ **less time awake during the night, maintained**

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

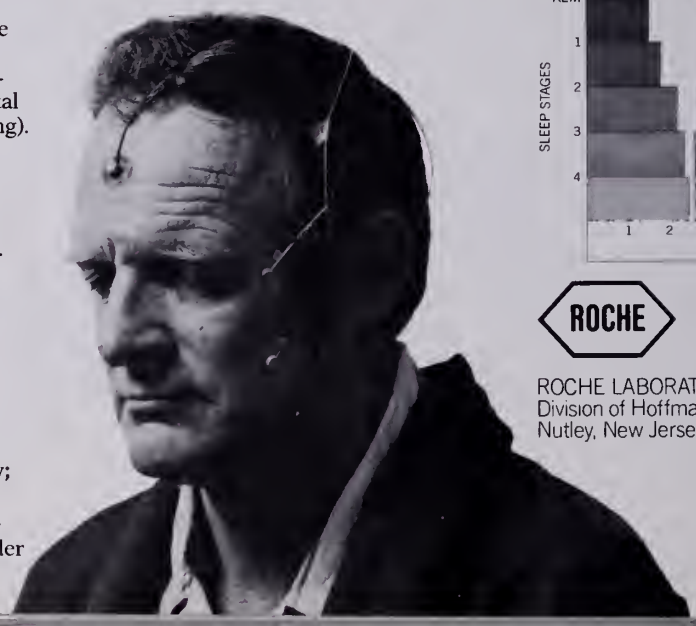
Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum benefi cial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

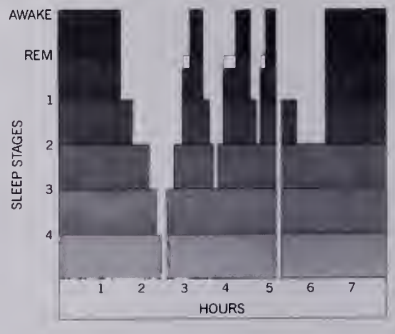
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



REFERENCES:

1. Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975
2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
3. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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ORGANIZATION

FMA Announces New Florida Physician's Insurance Reciprocal

W. Harold Parham, D.H.A.

A formal filing by the Florida Physicians' Insurance Reciprocal was made with the Department of Insurance, State of Florida, on November 10, 1976, to become effective January 1, 1977. The Reciprocal, when approved, would replace the FMA-PLI-Trust. From a beginning of 1,000 members in December, 1975, the Florida Medical Association-sponsored, Professional Liability Insurance Trust has grown to over 4,500 members. During the year, the Trust has accumulated enough reserves to convert to a Reciprocal Insurance Company.

The main advantage of the new Reciprocal over the Trust is that it will eliminate the assessability feature of the Trust to its members. The Reciprocal will in the beginning write only professional liability insurance. As the reserves accumulate and as the need arises, the Reciprocal will consider offering other lines of casualty insurance.

The ability to transform to the Reciprocal has been made possible by more than adequate reserves as required by the Department of Insurance and the reinsurance which we have been able to obtain from the Lloyds of London and others. To have started a Reciprocal a year ago when the Trust became operational would have required each member to provide a contribution to capital which would have approximated the member's annual premium for his professional liability insurance coverage.

The Reciprocal will continue to offer $500,000 claims made insurance with no aggregate as has the Trust. The change from the Trust to the Reciprocal will be accomplished in an orderly fashion so that there will be no interruption in coverage for those members presently in the Trust. The Reciprocal will receive the assets and liabilities of the Trust in order to insure complete continuity of the present Trust members.

The original 25 Subscribers have elected to the Advisory Committee (Board of Directors) of the Reciprocal the same four physicians who have served as Trustees for the Trust during 1976. They are Doctors Vernon B. Astler, Jack A. MaCris, Richard S. Hodes, and O. William Davenport. The Attorney in Fact, a requirement by law, will be W. Harold Parham, D.H.A., Executive Vice President of the Florida Medical Association. The Professional Insurance Management Company (PIMCO) will administer the Reciprocal by contract with the Attorney in Fact as it has served the Trust since its inception.

It will be necessary for each member of the Trust to complete a short application for coverage by the Reciprocal and receive a cancellation of his coverage by the Trust. Upon receipt of the proper forms, they should be completed by you and returned to PIMCO as soon as possible in order that an orderly transition may occur.

The target date for this conversion will be January 1, 1977, and all agreements previously issued by the FMA-PLI-Trust are to be cancelled as of Midnight, December 31, 1976, when the Trust will cease to exist and the Reciprocal begins.

Dr. Parham is Executive Vice President of the Florida Medical Association.

1977 Professional Liability Insurance Premiums

James W. Walker, M.D.

Physicians currently insured by the FMA-PLI-Trust will receive the Premium Notices for professional liability insurance from PIMCO for 1977, early in December, 1976. The Premium Structure was submitted to the Department of Insurance on November 10, 1976. Elsewhere in this issue is an article concerning the conversion from the FMA-PLI-Trust to the Florida Physicians' Insurance Reciprocal which should occur at Midnight, December 31, 1976, when the Trust will cease to exist and the Reciprocal will begin.

The Reciprocal will continue to offer $500,000 claims made insurance with no aggregate of which approximately $100,000 will be retained by the Reciprocal and $400,000 reinsurance will be purchased from the Lloyds of London and others. In theory, the premium for claims made insurance should escalate each year until the fourth year when it should approximate that of an occurrence policy.

One then might conclude that the second year premium would be double that paid the first year for claims made coverage. Two independent actuaries and our reinsurers in London considered the Legislative achievements in Florida in 1975 and again in 1976 and credited a substantial reduction in the premium which will be less that that which normally would have been expected. The application of investment credits, the success of the new Trust and its low cost of administration contributed significantly to a lower premium factor. In addition, the 1976 premium structure contained a surplus of some 40 percent of which one fourth has been escrowed to Lloyds, in an account to be released in 1981, pending the final results of the 1976 policy year. If the results are better than that which were originally anticipated this money would revert to surplus.

If on the other hand, the results were worse than anticipated, these escrowed monies would go to the reinsurers. The other three-fourths of these surplus monies have been credited in an investment account in each participant's name until 1981. Members who were previously in the Trust during December 1975 or 1976 will not make this contribution since they have already done so. New members joining the plan on or after January 1, 1977 will continue to make the same dollar-amount contribution that the older members of the Trust have made.

For those members who were in the Trust during December, 1975, and/or any part of 1976, there will be an increase of 33 1/3 percent. For those new members joining the Trust in 1977, the increase over the 1976 premium structure will be 3.9 percent. The lesser increase for the new member in 1977 is a result of the claims-made insurance coverage since this member has no exposure for which we must insure during the year 1976. It is anticipated by the actuaries that in any one policy year approximately 25 percent of the claims should be received during that year and 25 percent of the claims for that year should come in each of the three following years. The effect then is that a member in 1977 who was in the Trust during 1976 must be insured for those actions of 1976 which will surface and be reported during the year 1977. In addition, he must purchase coverage for the year 1977. The coverage is lumped into one policy instead of two in practice, thus the higher premium.

The experience of the Trust to date has exceeded our expectations when it was begun. However, it is too early to measure the success of the Trust and our actuaries must consider our experience for the years 1973, 1974 and 1975 in determining the 1977 Premium Structure. As we enter into renegotiations in the summer of 1977, we would expect that trend factors will begin to develop which our actuaries measure and apply in the premium determination for 1978.

While it is impossible to ascertain what the premium structure of 1978 will be at this early date, the arrest in the increase in 1977 gives hope that the curve is breaking, and in the year 1978 we will experience little or no increase and perhaps even a slight reduction in our premiums. It is simply too early to forecast as there are too many variables which will have to be considered. Your Trustees have acted

Dr. Walker is President of PIMCO in Jacksonville.

conservatively in order to insure the integrity of this plan. To have had no increase in premiums in 1977 would, in the opinion of all concerned, have placed the financial structure of this plan in jeopardy and would have precluded the formation of the Reciprocal. The Florida Medical Association, the Trustees of the FMA-PLI-Trust, and PIMCO are dedicated to doing these things necessary to insure the availability of actuarially sound coverage at a reasonable rate while attempting to find a permanent solution to the medical malpractice problems of our state.

Two Physicians Win Re-Election To State Legislature

Florida physician representation in the State Legislature has been reduced from four to two as a result of this year's primary and general elections.

The only physicians returning to Tallahassee when the Legislature convenes will be State Rep. Richard S. Hodes, M.D., of Tampa, and State Rep. David J. Lehman, Jr., of Hollywood. Both are Democrats.

With no opposition, Dr. Hodes was home free for his 6th two-year term in the House of Representatives. Dr. Lehman was voted in to his second term in a general election race with American Party candidate Linda Scott.

Veteran legislators David C. Lane, M.D., of Fort Lauderdale, and Walter W. Sackett, M.D., of Miami, will not be back. Dr. Lane, a Republican, did not seek reelection to his 31st District Senate Seat, which he had occupied since 1967. Dr. Sackett, a Democrat, was defeated in the primaries.

Also losing in the primaries were former State Sen. John J. Fisher, M.D., of Jacksonville and Robert E. Windom, M.D., of Sarasota. Dr. Fisher ran as a Democrat in an unsuccessful bid to oust Sen. Mattox Hair. Dr. Windom lost by a thin margin in the Republican District 74 House race.

Making his second bid for the U.S. Senate, John Grady, M.D., of Bellé Glade, running as a Republican, lost in the November 2 general election to the incumbent Democrat, U.S. Sen. Lawton Chiles of Lakeland.

Annual Meeting Scientific Program Approved For AMA Category 1 Credit

The Scientific program for the 103 Annual Meeting of the Florida Medical Association next spring has been approved for 20 hours of AMA Category 1 continuing medical education credit.

This will give physicians attending the sessions an opportunity to earn a full year's quota of Category 1 credit toward the AMA Physician's Recognition Award and of mandatory credit under FMA's mandatory education program for members.

Florida's three medical schools—the Universities of South Florida, Florida and Miami—have joined the FMA as co-sponsors of the program. As institutions whose CME programs have been accredited by AMA, they have designated the FMA scientific program as acceptable for Category 1 credit.

The Annual Meeting scientific program will get under way on Wednesday, May 4, 1977, with a Symposium on the Medical and Surgical Approaches to Stroke, sponsored by the Committee on Continuing Medical Education. Sessions will be conducted at the Americana Hotel in Bal Harbour.

A basic life support certification program will be co-sponsored by the Florida Chapter of the American College of Emergency Physicians in cooperation with Heart Association of Greater Miami. So that more physicians can be accommodated, the program will be run in two sessions and will be open to spouses and other family members as well as physicians.

A special scientific program for members of the Woman's Auxiliary to the Florida Medical Association is being arranged by the Committee on CME, according to O. Frank Agee, M.D., of Gainesville, Annual Meeting Program Chairman. Thomas B. Thames, M.D., of Orlando, has been designated as chairman for the special program, and details will be announced in a future issue of The Journal.

The following section programs have been completed since the preliminary program was published in the November issue of The Journal:

THURSDAY AFTERNOON—MAY 5

SECTION ON FAMILY PRACTICE

(Co-sponsored by Florida Academy of Family Physicians)

Thursday—1:30 p.m. to 5:30 p.m.

D. Robert Howard, M.D., Tampa
Program Chairman

Objectives of the Section — D. Robert Howard, M.D., Professor and Chairman, Department of Family Medicine, University of South Florida College of Medicine, Tampa

"Current Concepts of Office Gynecology," James M. Ingram, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa

Questions and Answers

"Learning Disabilities in Children," Richard F. Kaine, M.D., Fort Pierce

Questions and Answers

Coffee Break

"Panorama of Drug Interactions," George E. Crevar, Ph.D., Regional Medical Director, Smith Kline & French Laboratories, Atlanta, Georgia

Questions and Answers

"Human Sexuality in Family Practice—1977," David W. Epley, Ph.D., Clinical Assistant Professor, Alice MacMahan, R.N., Director, Parent Education, and Orris O. Rollie, M.D., Clinical Associate Professor, Family Practice Residency Program, Florida Hospital, Orlando

Questions and Answers

Adjournment

SECTION ON PSYCHIATRY

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

Thursday—1:30 p.m. to 4:20 p.m.

Samuel I. Greenberg, M.D., Miami
Program Chairman

"Current Drug Usage in Psychiatric Practice"

"Treatment of Target Symptoms," Edward H. Georgia, M.D., Chairman, Department of Psychiatry, St. Francis Hospital, Miami Beach

"Long-acting Thenothiazines," Joel Grossman, M.D., and Jaime

Fontane, M.D., Clinical Instructors in Psychiatry, University Miami School of Medicine, Miami

"Lithium Carbonate: Recent Findings," James J. Goodman, M.D., Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami

"Drug Usage in Child Psychiatry," Warren W. Schlanger, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami

"Treatment of Affective Disorders," William L. Gustafson, M.D., Clinical Assistant Professor of Psychiatry, University of Miami School of Medicine, Miami

Open Discussion (Entire Panel)

Adjournment

FRIDAY MORNING—MAY 6

SECTION ON BASIC LIFE SUPPORT CERTIFICATION
SECTION I
(Co-sponsored by Florida Chapter, American College of Emergency Physicians in Cooperation with the Heart Association of Greater Miami)
Friday—8:00 a.m. to 10:45 a.m.

Basic life support is an emergency first aid procedure that consists of the recognition of respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life until a victim recovers sufficiently to be transported or until advanced life support is available

The 1976 FMA House of Delegates encouraged all Florida physicians to become certified in basic life support

Participants may register for either of two sessions:

Friday morning, May 6 - 8:00 to 10:45 a.m.
Friday afternoon, May 6 - 2:00 to 5:00 p.m.

This course is open to spouses and other family of FMA members. A registrant who successfully completes one of the sessions will receive certification in basic life support from the American Heart Association

This course is practical in nature and registrants should be prepared to participate actively. A demonstration of practical skills is a prerequisite for successful course completion and certification

FRIDAY AFTERNOON—MAY 6

SECTION ON COLON AND RECTAL SURGERY
(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
Friday—1:30 p.m. to 5:00 p.m.
Manuel L. Carbonell, M.D., Miami
Program Chairman

"Changing Concepts of Colo-Rectal Cancer," Malcolm C. Veidenheimer, M.D., Chairman, Section of Colon and Rectal Surgery, Lahey Clinic Foundation, and Lecturer in Surgery, Harvard Medical School, Boston, Mass.

"The Use of Local Anesthesia in Ano-Rectal Surgery," Frederick E. Farrer, M.D., Miami

"Unusual Manifestations of Endometriosis," Carlos Alvarez, M.D., San Salvador; and Manuel Carbonell, M.D., Clinical Instructor in Surgery, University of Miami School of Medicine, Miami

"Supra Levator Fistula—the Iatrogenic One," Emmet F. Ferguson, M.D., Clinical Assistant Professor of Surgery, University of Florida College of Medicine (JHEP), Jacksonville

"Uncommon Colonoscopic Findings," John P. Christie, M.D., Miami

"Intraoperative Testing of Left Colon Anastamoses," Shed H. Roberson, M.D., Daytona Beach

Questions and Answers

Adjournment

SECTION ON BASIC LIFE SUPPORT CERTIFICATION
SECTION II
(Co-sponsored by Florida Chapter, American College of Emergency Physicians in Cooperation with the Heart Association of Greater Miami)
Friday—2:00 p.m. to 5:00 p.m.
See Program Under Friday Morning

SECTION ON ORTHOPEDIC SURGERY
SECTION I
(Co-sponsored by Florida Orthopedic Society)
Friday—2:00 p.m. to 5:25 p.m.
Richard G. Onkey, M.D., Naples
Program Chairman

"Peroneal Compartment Syndrome in Athletes," Thomas Haney, M.D., Tallahassee

Discussion

"University of Miami Interpretation of the Double Blind Study of Chymopapain," Mark D. Brown, M.D., Assistant Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"Anterior Cervical Fusion—Clinical Experience," A. Clarke Miller, M.D., Sarasota

Discussion

"Total Knee Replacement—Evolution of Design," Roderick H. Turner, M.D., Massachusetts General Hospital, Boston, Massachusetts

Discussion

"Use of the Functional Status Examination in Rehabilitation," Howard P. Hogshead, M.D., Clinical Associate Professor of Orthopedic Surgery, University of Florida College of Medicine (JHEP), Jacksonville

Discussion

"Infections of the Hand," Ronald J. Mann, M.D., Assistant Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"An Unusual Presentation of Osteomyelitis," William A. Stolzer, M.D., Fort Pierce

Discussion

"Autologous Blood Transfusion and Total Joint Replacement Surgery," James L. Cain, M.D., Vero Beach

Discussion

Adjournment

SECTION ON RADIOTHERAPY
SECTION I
(Co-sponsored by Florida Radiological Society)
Friday—2:00 p.m. to 4:30 p.m.
Phillip C. Smith, M.D., Gainesville
Program Chairman

Selected Topics To Be Announced

Guest Speaker: Robert G. Parker, M.D., Immediate Past President, American Society of Therapeutic Radiologists, and Professor of Radiotherapy, University of Washington School of Medicine, Seattle, Washington

Adjournment

SATURDAY MORNING—MAY 7

SECTION ON ORTHOPEDIC SURGERY
SECTION II
(Co-sponsored by Florida Orthopedic Society)
Saturday—8:15 a.m. to 12:50 p.m.
Richard G. Onkey, M.D., Naples
Program Chairman

"Acute Hematogenous Osteomyelitis in the Growing Child," Greer Busbee, III, M.D., Clarksville, Tennessee

Discussion

"Supracondylar Fractures of the Humerus in the Adult," Wallace E. Miller, M.D., Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"Tibial Osteotomy in Osteoarthritis of the Knee," Irwin M. Leinbach, M.D., St. Petersburg

Discussion

Coffee Break

"Slipped Capital Femoral Epiphyses in Blacks," John J. Jennings, M.D., Assistant Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"Management of Complications of Total Hip Replacement," Roderick H. Turner, M.D., Massachusetts General Hospital, Boston, Massachusetts

Discussion

"Preservation of Tissue in Fingertip Injuries," Merlin G. Anderson, M.D., Assistant Professor of Surgery, University of South Florida College of Medicine, Tampa

Discussion

"Adolescent Sports Injuries," Arthur Pearl, M.D., Clinical Assistant Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

"Anterior Cervical Fusion Utilizing Freeze Dried Cadaver Bone in Acute Spinal Cord Injury," Jerry E. Enis, M.D., Assistant Professor of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

"Spine Fusion—L4 to L5," George T. Rahilly, M.D.,Fort Lauderdale

Discussion

"Experiences with Functional Bracing of Humeral and Ulnar Fractures," Augusto Sarmiento, M.D., Professor and Chairman, Department of Orthopedic Surgery, University of Miami School of Medicine, Miami

Discussion

Adjournment

SECTION ON RADIOTHERAPY
SECTION II
(Co-sponsored by Florida Radiological Society)
Saturday—8:30 a.m. to 10:45 a.m.
Phillip C. Smith, M.D., Gainesville
Program Chairman

Selected Topics To Be Announced

Guest Speaker: Robert G. Parker, M.D., Immediate Past President, American Society of Therapeutic Radiologists, and Professor of Radiotherapy, University of Washington School of Medicine, Seattle, Washington

Adjournment

SECTION ON NEUROSURGERY
(Sponsored by Florida Neurosurgical Society)
Saturday—8:30 a.m. to 11:30 a.m.
Hubert A. Aronson, M.D., Miami
Program Chairman

Selected Papers by Members of the Florida Neurosurgical Society—Speakers and Topics to be Announced

Adjournment

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY
(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)
Saturday—9:00 a.m. to 12:00 noon
Jack D. Norman, M.D., Miami
Program Chairman

Selected Papers by Plastic Surgery Residents at the University of Miami School of Medicine - Speakers and Topics to be Announced

Selected Papers by Members of the Florida Society of Plastic and Reconstructive Surgery - Speakers and Topics to be Announced

Out-of-State Guest Speaker - Speaker and Topic to be Announced

Adjournment

Conference on the Identification of Needs and Standards for In-Hospital Critical Care

On September 11 and 12, the Florida Foundation sponsored a multidisciplinary Conference on the Identification of Needs and Standards for In-hospital Critical Care. The Florida Medical Association's Committee on Emergency Medical Services and Emergency Communications acted as the planning group for this unique Conference.

The meeting was held at the Host International Hotel in Tampa. More than 150 persons attended the two day gathering which was funded by a grant from the EMS Section of the Health Program Office. The following summary remarks were made by David O. Westmark, M.D., at the conclusion of the Conference:

"I feel that no one present today will take issue with Dr. Huntley's letter to Dr. Trask stating that, 'there are a number of currents pushing emergency medical care toward an organized plan for assuring that every major emergency which has the potential of producing death or disability shall have access to that facility which has the greatest capability for care.'

"Any patient whose clinical needs exceed the capability of a facility or physician should be referred to a facility or physician who can provide optimal care for that patient.

"There is general agreement that a minimal experiential base is essential to maintenance of clinical skills to optimally deal with some kinds of clinical problems.

"There is also general agreement that the population base from which such experiential basis may be derived varies with the clinical problem under consideration. For more common clinical problems, an appropriate level of expertise for optimal care can be maintained in multiple facilities and by multiple physicians in a given geographical area. For less common clinical problems, fewer facilities or physicians may be appropriate in the same geographical area.

"While there has been substantial agreement on the foregoing general principles, we have heard different responses to the prospect of formalization of facility capability, referral systems and stratification of care. There is general agreement for specific subject areas related to the basic principles propounded above:

"1. **Communications**—There is agreement on the need for enhanced communications among all components of an acute care system. Specifically, there must be communication between rescue and other pre-hospital emergency care units and responsible physicians. There must be enhanced communication between and among acute care facilities; this should be accomplished by development of a central toll-free telephone number through which optimal referral and facility utilization can be effected.

"2. **Financing**—The cost of acute care is a matter of considerable importance and is the basis for many of the problems encountered in effecting inter-facility transfer of patients. There is a consensus that financial support for patients referred from one facility to another should be made available by State government.

"3. **Professional Judgement**—The referring physician's professional judgment as the ultimate determinant of the need (or lack of need) for referral of any patient must be preserved.

"4. **Continuing Evaluation**—Because of the high rate of change of medical care standards, facility capabilities, and modes of delivery of health care, continued evaluation of the matter of stratification and/or categorization of care is necessary—through dialogue fostered by programs such as this conference.

"We have identified certain problem areas which should be a basis for continued dialogue among all health care professionals in all aspects of assuring optimal care for patients in the emergency care system:

"1. Expertise—The professionals themselves must determine the experiential base, facility capability and clinical training appropriate to various levels of care.

"2. Participation—Careful attention must be directed by health care professionals to minimize the ego threat which some physicians might feel implicit in referral of patients within a stratified care system.

"3. Financial—In considering the matters of stratified and/or regionalized health services, consideration must be given to the financial impact of the stratification or regionalization on the patient and his family as well as on the institutions involved.

"4. Sociological—The sociological, or emotional, impact on patients and their families must be considered in the development of a stratified acute care system.

"5. Medicolegal—The development of stratified or regionalized acute care systems must take into account the medicolegal ramifications of the system.

"At this conference we have had some very productive dialogue among health professionals who are concerned about and responsive to the needs of emergency medical services. We have evaluated a variety of opinions and viewpoints and have identified certain areas of agreement and other areas which present certain problems. We have developed some ideological and data bases which will prove to be valuable not only in terms of further development of emergency medical services, but also in terms of promoting further dialogue among health professionals."



These three doctors played key roles in the Florida Medical Foundation's Conference on the Identification of Needs and Standards for In-hospital Critical Care in Tampa in September. Left to right: Henry C. Huntley, M.D., former Administrator, Emergency Medical Services Section, Florida Health Program Office; Earl Kennemer, D.D.S., Administrator, Emergency Medical Services Section, Department of Health, Education and Welfare, Washington, D.C.; and Arthur L. Trask, M.D., Chairman, FMA Committee on Emergency Medical Services and Emergency Communications.

FMA-PLI-Trust-PIMCO Announce New Risk Management Program for Florida Hospitals

James W. Walker, M.D.

Physicians representing medical staffs, presidents of county medical societies and representatives from several hospitals' Board of Trustees and Administrators met on September 11-12, 1976, in Tampa to review recently enacted legislation concerning medical malpractice and to learn of the Professinal Insurance Management Company's (PIMCO) Risk Management Consultation Service Program for hospitals.

The two-day seminar, sponsored by the Florida Medical Association, Inc., the FMA-PLI-Trust, and PIMCO was attended by more than 230 representatives. Participating as speakers were the Trustees of the FMA-PLI-Trust--Vernon B. Astler, M.D., Jack A. MaCris, M.D., State Rep. Richard S. Hodes, M.D. and O. William Davenport, M.D. In addition, George T. Singleton, M.D., Acting Hospital Director of Shands Teaching Hospital and Clinics, and State Senator David C. Lane, M.D., a member of the Florida Senate for 10 years, participated in the program. A panel presided over by Circuit Judge Harold R. Vann also included John W. Thornton, Attorney-at-Law; Gloria Ellis, representative of the Dade County Clerk's Office; Alan Wagshul, M.D. and Mr. John E. Thrasher, FMA Legal Counsel who discussed Medical Liability Mediation Panels.

Legislative accomplishments of the past two years were reviewed. The recently enacted Risk Management Law was reviewed, and its implications considered. The need for physician participation and physician-hospital cooperation was stressed.

PIMCO revealed its new Risk Management Consultation Service which is available to hospitals on a contractual basis. This Loss Dollar Containment Program was discussed by James W. Walker, M.D., President of PIMCO and Mr. John H. Roberts, Vice President of PIMCO for Risk Management. W. Harold Parham, D.H.A., Executive Vice President of the FMA, summarized the seminar and in his concluding remarks, challenged those individuals present to continue to work to achieve quality patient care through their collective resources.

The program was enthusiastically received by the participants. There was ample time for questions and answers and free discussion concerning the presentation of each topic. We have received many requests for a mini-version of this seminar from county medical societies and hospital medical staffs. Several have already been conducted by PIMCO.

Information concerning the scheduling of such a meeting regarding PIMCO's Risk Management Program, Medical Mediation Panels, and Medical Incident Committees may be obtained by contacting Mr. John H. Roberts, Vice President of Risk Management for PIMCO at:

1-800-342-8349 (WATS) or (904) 354-5910

Dr. Walker is President of PIMCO in Jacksonville.

Risk Management Pictorial

The Journal's candid camera visited the Risk Management Seminar in Tampa, September 11-12. Left lower column: FMA President Jack A. MaCris, M.D. Center top: Reginald J. Stambaugh, M.D.; Mr. Michael Lopez, Executive Vice President of the Palm Beach County Medical Society, and J. Russell Forlaw, M.D. Center left: James W. Walker, M.D., President of PIMCO; Mr. George S. Palmer, Manager of the FMA Capital Office, and Mr. William E. Coletti, Executive Director of the Palm Beach County Medical Society. Bottom: Circuit Judge Harold R. Vann and Attorney John W. Thornton. Top right: Louis C. Murray, M.D., FMA President-Elect. Center: Alan Wagshul, M.D., and Ms. Gloria Ellis of the Dade County Clerk's Office. Bottom: State Sen. David C. Lane, M.D., and Vernon B. Astler, M.D., FMA Immediate Past President.











Photos by John W. Glotfelty, M.D.

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Complete literature available on request from Professional Services Dept. PML.



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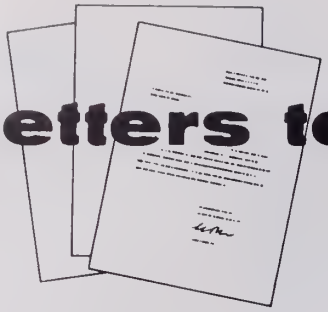
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Letters to the Editor

To The Editor: I read the recent article on the Soviet Psychiatric System entitled "Notes on Russian Psychiatry" with dismay. The statement by Dr. Phillips that psychiatric "detention of protestors against the government was not a function of the psychiatrists themselves" does not absolve the Soviet psychiatrists from their participation and the misuse of their sacred trust.

I think it is imperative that visiting American physicians question their Russian colleagues about psychiatric hospitalization of political dissidents. Our silence on the topic gives tacit approval; our outspoken public objection to the practice is the only way we can stop it.

Joel S. Sandberg, M.D.
Chairman,
Medical Mobilization for Soviet Jewry
Southeast Region
Hollywood

To the Editor: Thank you for referring Dr. Sandberg's letter to me for comment. I appreciate his opinion and his position on this matter. I would refer him to the October 1 issue of the Psychiatric News which discusses this matter in detail. Our group was headed by Dr. Jules Masserman and Dr. Judd Marmor who are officials of the APA. We met and were entertained by a number of senior psychiatrists of the Soviet Union including Prof. Snezhnevsky who is not only a psychiatrist, but is the senior political representative of medicine in the Soviet Union. Through his efforts we were permitted to visit the various hospitals in the cities included on our tour. A reasonably free exchange of professional information existed in our joint meetings with Russian psychiatrists. Personally I would have thought it not in keeping with the purpose of our visit were we to voice a vigorous protest against a practice of their government to professionals who were being our hosts. Among ourselves we discussed this matter and had the impression that any such detention of political prisoners in psychiatric facilities was not the will of the psychiatrists themselves, but an arbitrary function of a dictatorial system of government wherein freedom is a foreign word. Certainly Dr. Sandberg can be assured that our failure to question the Russian psychiatrists about this point did not imply endorsement or approval of their actions by our group of visiting psychiatrists. Certainly, we may speak out in our World Psychiatric Association and thru other media, but to protest to our hosts our disapproval of any actions on their part which were dictated to them by their system of government seemed inappropriate to us. Thank you for the opportunity to comment.

Philip B. Phillips, M.D.
Pensacola

To the Editor: I recently was asked to furnish a letter of recommendation to the U.S. Marine Corps by a former patient. The form was replete with assurances that the information I provided was to be treated with complete confidentiality, and the form was stamped confidential.

The applicant was, in my opinion, unstable and unsuitable for service and so stated on the form.

The recruiting office was not only careless and let the candidate read the information I had supplied, but put the entire package of information gathered on him in his hands to carry with him from Gainesville to Jacksonville!! Ah yes, it was in a sealed manila envelope and he was instructed that he should not read the contents.

I found out about this through the applicant's family and called the Marine recruiting office, working my way up from a private to a major in Orlando. He informed me that every applicant now has the right to see all letters of reference in their folder!

Colleagues - Beware!

Reformed recommender,
R.A.H.

Walter G. Jarrell, M.D.
10 University Boulevard N.
Jacksonville, Florida

Dear Dr. Jarrell:

This letter is to confirm and explain the reasons for the dismissal with prejudice of my medical malpractice claim against you in the Circuit Court of Duval County, Florida.

As you are probably aware, the lawsuit was filed on June 25, 1975, in proper person (filed by me rather than an attorney). This was for the reason that upon consultation with an attorney, I was informed that the applicable Statute of Limitations would run (making it impossible to file the lawsuit) within a short period of time. The attorney was unwilling to file the lawsuit in my name because he had no opportunity to make an investigation into the merits of the case but did advise that if I wanted to preserve my cause of action it would be necessary to file the lawsuit without delay.

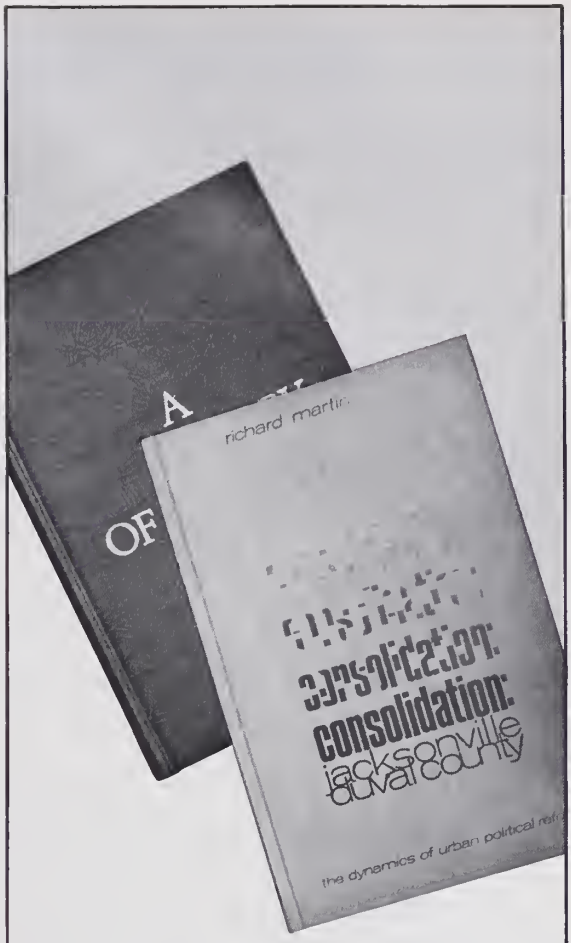
Since the lawsuit has been filed and an attorney retained in the case, much investigation has been made into the merits of the case. My attorney advises me that he is unable to find any evidence of malpractice on your part whatsoever and that the lawsuit, therefore, appears to be without merit. Therefore, I offer my sincere apologies for any inconvenience or embarrassment caused you with your colleagues or patients.

You may publish this letter without qualification for any purposes you deem appropriate.

Very sincerely,
Ben L. Reid
Jacksonville

I believe that every right implies a responsibility; every opportunity an obligation; every possession a duty.

John D. Rockefeller, Jr.



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Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

Emergency Medical Care: Emergency Management of the Critical Patient by J. Clifford Findeiss, M.D. Price $17.95. Stratton Intercontinental Medical Book Corporation, New York, N.Y., 1976.

This is a concise compilation of 25 well-written papers presented at the Second Annual Postgraduate Seminar on Emergency Medicine held in Miami Beach. Not surprisingly, all the authors (one of whom is an RN, another an inhalation therapist), except one, are based in Miami.

The gamut of emergencies a medical practitioner would have to deal with is adequately covered —from arrhythmias and A-V block to trauma, from Gram-negative sepsis to mass casualties. It is a volume intended not only for emergency room physicians—but also GPs, internists, surgeons and other specialists.

Most of the articles are up-to-date and straight to the point. Two separate papers dealing with resuscitation equipment could have been written into one. Allied medical personnel (nurses, emergency room technicians, inhalation therapists, physician assistants, etc.) would do well to read this volume.

A detailed discussion by the editor on protocol for on-site critical care currently in use can serve as a standard for the rest of the country. An excellent article on values, interpretations and limitations of the laboratory as an invaluable tool was presented to emphasize its use to substantiate diagnosis rather than aid in differential diagnosis. Pathophysiology of critical conditions were explained in simple, down-to-earth terms, e.g., by analogies.

An otolaryngologist wrote a dynamic classic on management of airway obstruction, while an anesthesiologist discussed emergency airway management and cardio-pulmonary resuscitation.

This book is a must for a practitioner's library.

T. D. Bonzon, M.D.
Jacksonville

Dr. Bonzon practices General Surgery and Industrial Medicine in Jacksonville.

First, You Cry. by Betty Rollin. 206 pages. Price $7.95. J. B. Lippincott Company, Philadelphia and New York, 1976.

Like so many of us, one night Betty Rollin found a lump in her breast and, like so many of us, chose to watch it for a time. Some watch longer than others. She and her physicians watched the lump for a year while she pursued her career as an NBC-TV news correspondent. Three weeks elapsed between the time I found the lump and surgery was scheduled. The results were the same, a modified, radical mastectomy.

I set this book aside for a few days thinking it was much like the other books and articles I had read, essays filled with cold statistics, grim chapters on how to deal with morbidly curious friends and strangers, what to wear to hide the disfiguration and, of course, how to handle the man in my life. Instead, I laughed and cried through a beautifully written, witty, informative narrative by an intelligent, perceptive woman who not only covered the more obvious feelings mastectomy candidates share but those other feelings we often keep hidden.

Most women experience post-surgical euphoria knowing a terrifying event is over. There is the dread of seeing the scar for the first time and the terrible panic which overwhelms us daily knowing death can be so near. Inner feelings of anxiety and anger are often vented at our own families, followed by guilt. Finally, after many months, most of us accept the loss. Rollin, with exquisite humor, also digs up those other thoughts we have that sometimes seemed less than sane. What woman has not imagined what she would do if confronted by a rapist? Rollin and I both had wondered if exposing the scar would repel him. We both suffered from "breast-envy syndrome" — glaring at some of our better endowed sisters. Knowing others share the same thoughts certainly lessens our own unhappiness and self-pity.

With warmth and humor Betty Rollin covers a

subject that was for so long a "closet disease." Breast cancer is still a topic which evokes shudders and averted gazes from strangers, friends and family. She feels, as we all do, that it will take time to heal both physically and emotionally from a mastectomy, as it would from any surgery that involved the loss of a physical part — that breast was with us for so long! This is an invaluable book for the post-mastectomy patient.

Suzanne Cohan
Pensacola

Mrs. Cohan is the wife of a physician. She had a mastectomy. Book Review Editor's Note: Occasionally the author of the book uses words not in excellent taste. This may be offensive to some.

Post-Mastectomy, by Win Ann Winkler. 197 Pages. Price $7.95. New York, Hawthorn Books, Inc., 1976.

A well written book by feature writer and fashion designer who underwent mastectomy. This book covers emotional recovery, diet, beauty care, exercise and clothing. A brief chapter discusses cancer quackery. Appendices consider cancer detection centers, shopping information for clothing and prosthesis. Bibliography included. Recommended to supplement advice from the physician.

Plagues and Peoples by William H. McNeill. 369 pages. Price $10.00. Garden City, N.Y., Anchor Press/Doubleday, 1976.

Professor McNeill of the University of Chicago sets out to "bring the role of infectious disease in shaping human history into a juster perspective than others have allowed." Beginning with the earliest historical records he successively traces in the various societies the first confrontation of man with disease producing microorganisms, the immediate "die-off," the gradual adaptation of man to the organism and the result of this series of events upon the history of society. Whereas others have dealt with single diseases or single societies, McNeill encompasses the effects of many epidemic diseases in the principal societies of the world up to the present time. While a very readable book, it also includes an extensive index and an annotated bibliography that make it a valuable reference work for the medical historian as well as the academic historian.

William M. Straight, M.D.
Miami

Dr. Straight is in the private practice of Internal Medicine in Miami and is the Historical Editor of the Journal.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

Solved: The Riddle of Heart Attacks by Broda O. Barnes, M.D., Ph.D. and Charlotte W. Barnes, A.M. 84 Pages. Price $2.50. Fort Collins, Colorado, Robinson Press, Inc., 1976.

Review of Medical Pharmacology, 5th Edition by Frederick H. Meyers, M.D., Ernest Jawetz, Ph.D. and Alan Goldfien, M.D. 740 Pages. Illustrated. Price $12.50. Los Altos, California, Lange Medical Publications, 1976.

Correlative Neuroanatomy & Functional Neurology, 16th Edition by Joseph G. Chusid, M.D. 448 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

Contact Lenses and Corneal Disease by Antonio R. Gasset, M.D. 403 Pages. Illustrated. Price $22.50. New York, Appleton-Century-Crofts, 1976.

Principles of Clinical Electrocardiography, 9th Edition by Mervin J. Goldman, M.D. 412 Pages. Illustrated. Price $9.95. Los Altos, California, Lange Medical Publications, 1976.

Review of Medical Microbiology, 12th Edition, by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D. 542 Pages. Illustrated. Price $10.00. Los Altos, California, Lange Medical Publications, 1976.

Current Pediatric Diagnosis and Treatment, 4th Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. 1,053 Pages. Illustrated. Price $15.00. Los Altos, California, Lange Medical Publications, 1976.

So Get On With It by Marilee Weisman & Jan Godfrey. 159 Pages. Illustrated. Price $8.95. Garden City, New York, Doubleday & Company, Inc., 1976.

Basic and Clinical Immunology edited by Hugh Fudenberg, M.D., Daniel P. Stites, M.D., Joseph L. Caldwell, M.D. and J. Vivian Wells, M.D. 653 Pages. Illustrated. Price $12.50. Los Altos, California, Lange Medical Publications, 1976.

Ganja in Jamaica, The Effects of Marijuana Use by Vera Rubin and Lambros Comitas. 240 Pages. Price $2.95. Garden City, New York, Anchor Press, 1976.

Sleep Disturbance and Hypnotic Drug Dependence edited by Anthony D. Clift, M.D. 352 Pages. Illustrated. Price $35.95. New York, Excerpta Medica/American Elsevier, 1975.

Confederate States Medical and Surgical Journal with an introduction by William D. Sharpe, M.D. 290 Pages. Illustrated. Price $22.50. Metuchen, New Jersey, Scarecrow Press, Inc., 1976.

Diving Medicine by Richard H. Strauss, M.D. 420 Pages. Illustrated. Price $21.00. New York, Grune & Stratton, Inc., 1976.

Nuclear Energy and National Security by the Research and Policy Committee of the Committee for Economic Development. 80 Pages. Illustrated. Price $2.50 paperbound, $4 hardbound. New York, Committee for Economic Development, 1976.



Robert Q. Marston, M.D. . . . President of the University of Florida, has been elected to the Board of Directors of the Hospital Corporation of America.

"His knowledge of the industry and experience in government health agencies will be most helpful to us," said HCA Board Chairman John A. Hill. Prior to assuming the Florida presidency, Dr. Marston was Director of the National Institutes of Health.

Richard K. Forster, M.D., of Miami . . . won the third place award in the ophthalmology film program during the recent annual meeting of the American Academy of Ophthalmology and Otolaryngology in Las Vegas.

Dr. Forster's film is entitled, "The Diagnosis of Keratomycoses." He is an Assistant Professor of Ophthalmology at the University of Miami School of Medicine.

Maurice H. Laszlo, M.D., of Miami . . . Clinical Professor of Medicine at the University of Miami School of Medicine, has been granted a Distinguished Alumnus Meritorious Award by the Chicago Medical School Alumni Association. The presentation was made at the Association's annual meeting on October 9.

A past president of the Dade County Medical Association, Dr. Laszlo is a member of FMA's Committee on Continuing Medical Education.

Franklin B. McKechnie, M.D., of Winter Park . . . has been re-elected Vice Speaker of the House of Delegates of the American Society of Anesthesiologists. Dr. McKechnie, a native of Boston, Mass., is Chief of Staff of Winter Park Memorial Hospital and is a former President of the Florida Society of Anesthesiologists.

The Lupus Foundation of Florida, Inc. . . . will conduct its first state convention at the new Civic Center in Lakeland, February 19, 1977. Information may be obtained from Mrs. Lillian Alby, Acting President, Lupus Foundation of Florida, Inc., P.O. Box 2414, Lakeland, Fla. 33803.

A Conference for Health Care Personnel . . . entitled "Advances in Medical Systems," will be held December 9-10 at the Royal Biscayne Beach Hotel and Racquet Club on Key Biscayne.

Speakers from industry, government and universities will discuss cost effectiveness of automated health care systems, health test facilities, cost effective hospital administration systems and medical instrumentation.

The conference is sponsored by the University of Miami biomedical engineering program and others. A registration fee of $175 will be charged.

Information is available from Dr. Jacob Kline, Director of Biomedical Engineering, University of Miami, telephone (305) 284-2442.

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SPEAKERS

INTERNAL MEDICINE
Ray W. Gifford, Jr. M.D.
Cleveland Clinic

NEUROLOGY
Herbert Karp, M.D.
Emory University
Clark H. Millikan, M.D.
Mayo Clinic
Robert G. Siekert, M.D.
Mayo Clinic
James Toole, M.D.
Bowman Gray School of Medicine

PEDIATRICS
Manuel Gomez, M.D.
Mayo Clinic

NEUROVASCULAR SURGERY
Robert G. Ojemann, M.D.
Massachusetts General Hospital
O. Howard Reichman, M.D.
Loyola Univ. Medical Center
James T. Robertson, M.D.
University of Tennessee
Jesse E. Thompson, M.D.
Baylor Univ. Med. Center
M. Gazi Yasargil, M.D.
Kantonsspital, Zurich, Switzerland

NEURORADIOLOGY
Juan M. Taveras, M.D.
Massachusetts General Hospital

PHYSICAL MEDICINE
Donald J. Erickson, M.D.
Mayo Clinic

NURSING
Dianne C. H. Bader, R.N.
Kantonsspital, Zurich, Switzerland
Kathleen Redelman, R.N.
Indiana University

PHYSICAL THERAPY
Martha Wroe, R.P.T.
University of Florida

SPEECH PATHOLOGY
Frederic L. Darley, Ph.D.
Mayo Clinic

REGISTRATION FEES:

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Physicians $175.00
Nurses and Allied Health Professionals $ 75.00

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Physicians $ 75.00
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FOR INFORMATION WRITE:
Mr. Ronald A. Nelson
Executive Director
American Heart Association
Broward County Chapter
440 North Andrews Avenue
Fort Lauderdale, Florida 33301

REGISTRATION CLOSES FEBRUARY 4, 1977.

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ACCREDITED BY THE J. C. A. H.



Others Are Saying

Doctors Who Play God

Sidney J. Harris

Editors Note: The following story was carried in many newspapers throughout the country. It was brought to our attention by a society member whose college student daughter sent it home. Maybe our children are trying to tell us something. . . .

A doctor I have been seeing lately was complaining bitterly—as they all do nowadays—about the skyrocketing cost of his malpractice insurance.

I asked him how many times in the 30 years of his flourishing practice he had been sued. "Not once," he admitted. "Do you ascribe this to your superior skill and talent?" I asked him.

"I guess not," he shrugged. "Just lucky."

"Just lucky, my foot," I said. "I'll tell you why you haven't been sued, even when you've made mistakes. It's because you're one of the few doctors who don't try to play God."

"What do you mean by that?" he asked.

"I mean that you level with your patients. You tell them what they want to know and need to know. You don't pretend to be omniscient and infallible. You try to treat them like intelligent human beings —and they appreciate it.

"More than that," I went on, "you talk to their family and relatives. You point out that you're only human, that mistakes are made, and every treatment has its calculated risk. Isn't that a fact?"

"Well, yes," he said. "I do try to make them feel that I care about them. That's the best way to get a patient to cooperate."

"Exactly," I went on. "The patients and families who sue doctors are not mercenary, except for a small percentage. The rest are just resentful. They resent not having been talked to like an adult. They resent the doctor's assumption that he is always right. And, most of all, they resent his trying to cover up when he makes a goof."

Instead of trying to "educate" the public to see medicine more from the doctor's point of view, the AMA and other medical groups should have been working at trying to educate the doctors to see medicine more from the patient's point of view.

Instead of being a powerful lobby to promote the medical industry's financial position, the AMA should have spent more time in developing patient relations, in showing doctors how to communicate with laymen and how to inspire confidence and trust in their characters as much as in their medical skills.

Malpractice suits are less a mercenary than a psychological reaction to the arrogance, vanity and impersonality of so many medical practitioners. They have risen in direct proportion to specialization, which severs the personal relationship the patient used to have with the old-fashioned general practitioner. When a doctor is a "corporation," why not sue it?

This is a Guest Editorial reprinted from the Picomeso Mail Bag of the Pinellas County Medical Society, May 1976.

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George Washington Carver



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• FOR FURTHER INFORMATION CONTACT DEPARTMENT OF EDUCATION at American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068

MEETINGS

Approved by FMA Committee on Continuing Medical Education

1976

DECEMBER

Death and Dying: Education, Counseling, and Care, Dec. 1-3, Hyatt Hotel, Orlando. For information: Suzan Schafer, M.D., 807 Seagle Building, Gainesville 32601.

Emergencies in Internal Medicine: Diagnosis and Management, Dec. 1-4, Americana Hotel, Miami Beach*

CAT Scan in Clinical Neurology, Dec. 2-4, Innisbrook, Florida. For information: William M. Haycock, M.D., 2550 Park St., Jacksonville 32204.

Fall Meeting Florida Society of Ophthalmology, Dec. 2-5, Marco Island Hotel and Villas, Marco Island, Florida. For information: Susan Waits, Florida Society of Ophthalmology, 346 Barnett Bank Bldg., Tallahassee 32301.

Clinical Workshop: In the Management of Common Sexual Problems, Dec. 9-11, Hilton Hotel, Gainesville**

The Role of Vasolidator Drugs in the Treatment of Hypertension, Dec. 9, Abbey Hospital Conference Room, Coral Gables. For information: Jose Martinez-Alba, M.D., 5190 Southwest 8th Street, Coral Gables 33134.

Highlights in Cancer—Part II, Dec. 10, Schultz Auditorium, St. Vincent's Medical Center, Jacksonville. For information: Ashbel Williams, M.D., 1661 Riverside Ave., Jacksonville 32204.

Mease Hospital Tumor Board, Dec. 16, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

1977

JANUARY

Pediatric Nephrology Seminar IV, Jan. 3-6, Miami*

Neuro-Ophthalmology Seminar, Jan. 3-7, Miami*

Initial Management of the Pediatric Emergency, Jan. 5-9, Konover Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

Medical Knowledge Self-Assessment Course, Jan. 5, 12, 19, Borland Medical Library, Jacksonville. For information JHEP, 655 W. 8th St., Jacksonville 32209.

Midwinter Cruise—Symposium on Intensive Care, Jan. 6-15, Miami*

Family Practice Weekend, Jan. 8, Tampa.+

First Symposium of Neurological Surgery of the Ear, Jan. 8-12, Sarasota Hyatt House at Watergate Center, Sarasota. For information: Herbert Silverstein, M.D., 1849 A Hawthorne, Sarasota 33579.

Topics in Clinical Hematology: Disorders in Maturation, Jan. 10-13, Ponte Vedra Beach. For information: Registrar, Postgraduate Courses, ACP, 4200 Pine St., Philadelphia, Pa. 19104.

Current Topics in Urology, Jan. 11, Manatee Memorial Hospital Auditorium, Bradenton. For information: Allen R. Sklerov, M.D., 525 3rd Street, East, Bradenton 33505.

Miami Winter Symposia—Biochemistry, Jan. 10-14, Miami*

Human Disease Related to Food and Chemical Sensitivity, Jan. 12-15, Miami*

11th Annual Postgraduate Seminar in Surgery, Jan. 12-15, Miami*

Hematology and Oncology 1977, Jan. 13-16, Miami*

Nephrology 1977, Jan. 14-15, Miami*

Pulmonary Disease 1977, Jan. 14-15, Miami*

Arthritis 1977, Jan. 14-16, Miami*

Gastroenterology and Hepatology 1977, Jan. 14-16, Miami*

Coronary Disease, Exercise Testing & Cardiac Rehabilitation, Jan. 14-16, Orlando Hyatt House, Orlando. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colo. 80110.

Internal Medicine 1977, Jan. 15-21, Miami*

Second Review and Practical Advances in Pathology, Jan. 16-21, Miami*

Fourth Annual Postgraduate Seminar in Pediatric Neurology, Jan. 17-21, Konover Hotel, Miami Beach*

Southeastern Breast Oncology Conference, Jan. 17-21, Marriott Hotel, Miami. For information: Oswald H. Coury, M.D., 7211 Southwest 62nd Ave., South Miami 33143.

Internal Medicine Update '77, Jan. 17-22, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1416 S. Orange Avenue, Orlando 32806.

Mease Hospital Tumor Board, Jan. 20, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

9th Annual Postgraduate Seminar in Pediatric & Adult Urology, Jan. 19-22, Carillon Hotel, Miami Beach. For information: Charles Lynne, M.D., 1200 N.W. 10th Avenue, Miami 33136

19th Annual Cardiovascular Seminar, Jan. 21-22, Tampa.+

Infectious Disease—Immunology 1977, Jan. 22-23, Miami*

Endocrinology 1977, Jan. 22-23, Miami*

Basic Sciences for the Practicing Physician: Biochemistry, Jan. 22-23, Miami*

Cardiology 1977, Jan. 24-26, Miami*

4th Annual Postgraduate Course in Practical Modern Neurology, Jan. 24-27, Miami*

Hematopathology, Jan. 26-28, Tampa+

Workshop in Echocardiography, Jan. 26-29, Sheraton Sand Key, Clearwater Beach. For information: Billie N. Chiles, Coordinator, Tampa Tracings, Box 1245, Tarpon Springs 33589.

Emergency Cardiac Care—1977, Jan. 27-30, Americana Hotel, Miami Beach. For information: J. Clifford Findeiss, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

***For Information: Contact Division of Continuing Education, University of Miami School of Medicine, P.O. Box 520875, Biscayne Annex, Miami 33152, Tel. (305) 547-6716.**

****For Information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143.**

+For Information: Contact Theron A. Ebel, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2074.

Florida Midwinter Seminar on Ophthalmology, Jan. 30-Feb. 2, Miami*

First International Glaucoma Congress, Jan. 31-Feb. 1, Diplomat Hotel, Hollywood. For information: John Bellows, M.D., 6 North Michigan Avenue, Chicago, Illinois 60602.

FEBRUARY

Medical Knowledge Self-Assessment Course, Feb. 2, 9, 16, Borland Medical Library, Jacksonville. For information: JHEP, 655 W. 8th St., Jacksonville 32209.

Update on Cancers of the Gastrointestinal System, Feb. 3-5, Sonesta Beach Hotel and Tennis Club, Key Biscayne.*

Florida Midwinter Seminar on Otolaryngology, Feb. 3-5, Miami*

Eleventh Annual Symposium on Cosmetic Surgery, Feb. 3-5, Cedars' South Building Auditorium, Miami. For information: Thomas J. Baker, M.D., 1501 South Miami Avenue, Miami 33129.

What's New in Neurosurgery for the General Practitioner, Feb. 4-5, Gainesville Hilton, Gainesville.**

Fred J. Wood Lecture Series III, Pediatrics and Adult G.U. Cancers, Feb. 4-5, Tampa.+

22nd Central Florida Medical Meeting, Feb. 4-6, Contemporary Resort, Lake Buena Vista. For information: Axel W. Anderson III, M.D., Suite 403, 85 West Miller Avenue, Orlando 32806.

3rd Annual Vail Conference in Anesthesiology, Feb. 5-12, Miami*

Thrombosis: Diagnosis, Prevention & Treatment, Feb. 7-9, Sonesta Beach Hotel, Key Biscayne. For information: Miniver S. Reed, 4300 Alton Road, Miami Beach 33140.

Tampa Bay Area Kidney Transplant and Procurement Program, Feb. 8, Auditorium, Manatee Memorial Hospital, Bradenton. For information: Allen R. Sklerov, M.D., 525 3rd Street E., Bradenton 33505.

Second Annual Seminar, Problems in Pediatric Radiology, Feb. 8-12, Dutch Inn, Lake Buena Vista.*

Symposium on Stroke—Moderns Trends in Cerebrovascular Disease, Feb. 9-12, Diplomat Hotel, Hollywood. For information: Mr. Ronald A. Nelson, Executor Director, Heart Association of Broward County, 440 N. Andrews Ave., Fort Lauderdale 33301

Midwinter Seminar in Ob/Gyn, Feb. 10-12, Tampa.+

Coronary Disease, Exercise Testing & Cardiac Rehabilitation, Feb. 11-13, Boca Raton Hotel & Club, Boca Raton. For information: William E. James, Ph.D., One Inverness Drive, Englewood, Colo. 80110.

Winter Management (Anesthesiology), Feb. 12-19, Miami*

Mease Hospital Tumor Board, Feb. 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Psychopharmacology for the Internist, Family Practitioner and Private Psychiatrist, Feb. 18-19, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1416 South Orange Avenue, Orlando 32806.

1977 Ear Surgery—Microsurgery in 3-D, Feb. 21-23, Tampa+

Pediatric Dermatology Seminar, Feb. 24, Konover Hotel, Miami Beach. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Avenue, N. Miami Beach 33169.

Recent Advances in Cardiopulmonary Care III, Feb. 25-26, Holiday Inn, Lido Beach, Sarasota. For information: Robert E. Windom, M.D., 1901 Arlington Street, Sarasota 33579.

Clinical Gastroenterology '77, Feb. 25-26, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., 1416 South Orange Avenue, Orlando 32806.

Basic Neurology for Psychiatrists, Feb. 28-Mar. 4, Miami*

5th Annual Workshop on Methods of Analysis and Principles of Instrumentation in the Clinical Laboratory, Feb. 28-Mar. 4, Tampa+

MARCH

Third Annual Pediatric Surgical Postgraduate Course, Mar. 3-5, Americana Hotel, Miami Beach. For information: William T. Brown, M.D., Chief, Department of Surgery, Variety Children's Hospital, 6125 S.W. 31st St., Miami 33155.

Selected Topics in Urology, Mar. 3-5, Hilton Hotel, Gainesville**

Postgraduate Seminar in Dermatology, Mar. 4-6, Miami*

Skin 1977: What Every Nurse Should Know, Mar. 4-6, Miami*

Pediatric Anesthesia Seminar—Spring Cruise, Mar. 5-15, Miami*

3rd Annual USF Cancer "Tumors of the Genitourinary Tract," March 5, Tampa.+

Annual Suncoast Trauma Seminar, March 9-11, Tampa.+

A Symposium in Gynecologic Endocrinology and Infertility, March 10-12, Hyatt House, Orlando. For information: B. Cantor, M.D., P.O. Box 13284, University Sta., Gainesville 32604

Basic Medical Hypnosis, Mar. 13-19, Miami*

Gynecologic Oncology Seminar, Mar. 15-26, Cruise*

Tenth Anniversary JHEP Instructional Course on Surgery of the Hand, March 16-20, Amelia Island. For information: Ira M. Dushoff, M.D., 580 W. 8th St., Jacksonville 32209.

Neurology for Non-Neurologist V: Movement Disorders, March 17, Tampa.+

Mease Hospital Tumor Board, March 17, Mease Hospital, Dunedin. For information: Paul S. Berger, M.D., 725 Virginia Street, Dunedin 33528.

Seventh Annual Special Radiological Procedures Seminar, Mar. 19-22, Konover Hotel, Miami Beach.*

Fifteenth Annual Clinical Radiology Seminar, Advances in Cancer Diagnosis, Mar. 22-26, Konover Hotel, Miami Beach.*

9th Teaching Conference in Clinical Cardiology, Mar. 23-26, Sheraton-Four Ambassadors Hotel, Miami.*

8th Annual Topics in Internal Medicine, Mar. 24-26, Hilton Hotel, Gainesville**

Cardiology, March 25-27, Contemporary Hotel, Lake Buena Vista. For information: Jonathan O. Partain, M.D., 1131 South Orange Avenue, Orlando 32806.

Post-Conventional Seminar, Pathologic-Radiologic Correlations, Mar. 26-29, Caribbean Cruise.*

2nd Annual Vail Conference in Respiratory Therapy, Mar. 26-Apr. 2, Miami*

Pulmonary Infection, Pulmonary Infarction (Embolus), Mar. 26-27, Tampa.+

Hepatitis: Diagnosis and Management, Mar. 31, Tampa.+

Index to Volume 63
January-December 1976

A Perspective of Acupuncture (Scientific) 123-2*
Acute Rheumatic Fever and Rheumatic Heart Disease (Editorial) 564-7

Annual Meeting:
- Annual Meeting Highlights 426a-6
- First House of Delegates 486-7
- General Session 484-7
- Index to Proceedings 590-7
- President's Address 479-7
- Second House of Delegates 490-7
- Third House of Delegates 524-7

Arthritis, Rheumatoid Variants (Scientific) 339-5

Blood Pressure in 1,305 Normal Neonates (Scientific) 971-12
Book Reviews and Books Received 158-2
234-3, 304-4, 376-5, 450-6, 572-7, 668-8, 732-9, 792-10, 934-11 1,018-12, 1019-12

Caduceus (Editorial) 139-2
Cardiac Pacemaker Treatment of Infected Site (Scientific) 349-5

Case Reports:
- Klinefelter Syndrome Associated with Atrial Septal Defect and Prolapse of Mitral Valve 421-6
- Sneeze Neuropathy 291-4

Colonoscopic Surgery (Scientific) 414-6
Cranio-Orbital Correction of Severe Facial Deformity A New Horizon in Corrective Surgery (Scientific) 345-5
Contributors to the Journal Make an Interesting Cluster (Editorial) 565-7

Dean's Page:
- Carnegie Foundation: 1910 and 1976 958-12
- Consultant for Troubled Times 19-1
- Continuing Medical Education 116-2
- Current Trends in Graduate Medical Education 406-6
- First Things First 689-9
- Growth of a Statewide On-Site Education Program (Cancer) 336-5
- Standards of Medical Education 184-3
- Standards of Quality in Medicine 264-4
- The Impact of Malpractice Costs on Medical Education 606-8
- The Last Page 826-11
- The Univerity of Miami, Jackson Memorial Medical Center 748-10
- University of South Florida Medical Center Dedication 468-7

*The first number is the page number, the second is the month of publication

Deaths—Members:
- Andrews, Edwin H., Cedar Key 162-2
- Barton, Maurice A., St. Petersburg 162-2
- Belgorod, Samuel H., Fort Myers 162-2
- Blair, William M., West Palm Beach 162-2
- Brede, Edward H., Fort Lauderdale 162-2
- Brown, Robert J., Jacksonville 800-10
- Cannon, Curtis W., West Palm Beach 800-10
- Claytor, Samuel B., Tampa 800-10
- Conkling, Frederick E., Miami 398-6
- Cooper, Sam M., Fort Walton Beach 162-2
- Des Jean, Paul A., Pompano Beach 800-10
- Ferguson, James H., Miami 398-6
- Fernandez, Jose M., Miami 800-10
- Ferrara, John D., Orange Park 800-10
- Goethals, Paul L., Winter Park 800-10
- Goodman, Bernard, Miami 162-2
- Goodnow, Chester L., Chatham, Massachusetts 162-2
- Gouaux, James L., St. Petersburg 398-6
- Griffin, George W., Alexandria, Louisiana 162-2
- Halpern, Jesse O., Miami Beach 162-2
- Hauss, John F., Miami Beach 162-2
- Holmes, James W., Miami 398-6
- Hoover, Russell D. D., Palm Beach 162-2
- Jones, Thee A., Orlando 162-2
- Kay, Harry D. L., Coral Gables 398-6
- Knight, Jimmie H., Tallahassee 398-6
- Lanier, William T., Coral Gables 800-10
- Leone, Frank, Venice 398-6
- Luce, Henry A., Naples 800-10
- Machle, Willard Sr., Coral Gables 800-10
- Mahrer, Martin P., Miami 800-10
- Manson, Plumer J., Miami 162-2
- Mason, William G., Clearwater 800-10
- Maxwell, Roscoe S., Punta Gorda 800-10
- McConnell, Whitman C., St. Petersburg 800-10
- Melich, Edward I., St. Petersburg 800-10
- Milam, Ernest B., Jacksonville 800-10
- Mills, Richard A., Fort Lauderdale 162-2
- Nadel, Morris, West Palm Beach 800-10
- O'Connor, James B., Tallahassee 162-2
- Ombres, L., Richard, West Palm Beach 398-6
- Pate, Julien C. Jr., Tampa 398-6
- Pate, Julien C. Sr., Tampa 398-6
- Perez, Guillermo J., Gainesville 398-6
- Peterson, Claus A., Fort Lauderdale 800-10
- Raulerson, Hiram H. Jr., Okeechobee 800-10
- Rorebeck, Curtis G., Tampa 398-6
- Rowe, Alvah L., Lake Worth 800-10
- Rumball, John M., St. Petersburg 800-10
- Scala, Raymond D., Winter Park 800-10
- Sisk, Wilfred, N., Orlando 800-10
- Templeton, Earl R., Hollywood 162-2
- Womble, William L., Deland 398-6

Depressed Patient, Early Strategies in Treatment of (Scientific) 271-4
"Doctoring" (Editorial) 1,002-12

"False Profits" and Response (Commentary) 662-8
Fasciitis (Eosinophilic) With Scleroderma-Like Changes in the Skin (Scientific) 702-9
Florida Maternal Mortality Report, Summary 1974 (Commentary) 441-6
Florida Nurse Practice Act Alert (Editorial) 365-5
Florida Swine Flu Update 991-12
Florida Organizations of Medical Interest 1,034-12
Flu Vaccine, Large Scale Program Planned (Commentary) 372-5
From the Editor's Desk 602-8, 642-9, 752-10 830-11, 964-12
Further Comments on the Fifth Pathway and Dr. McSwain's Guest Editorial (Editorial) 142-2

His Bundle Recordings in the Clinical Evaluation of Patients with Conduction Disturbances (Scientific) 695-9
Home Management of Vomiting and Diarrhea (Scientific) 129-2
Hypertension Evaluation (Scientific) 975-12

Index to Volume 63 1,028-12
In Memoriam:
Curtis W. Cannon, M.D. 656-8
Reuben B. Chrisman, M.D., 1911-1975 88-1
Interim Meeting-FMA House of Delegates:
First House of Delegates 213-3
Second House of Delegates 217-3
General Session 224-3

Legislative News:
April Showers 260-4
Consumerism 403-6
Know These Men 120-2
On Chronic Diseases 180-3
Pot Pourri 332-5
The Nitty Gritty 472-7
"There Are Two Things...." 10-1
Letters to the Editor 160-2 238-3, 303-4, 379-5, 445-6, 726-9, 805-10 1016-12
Liability Insurance Coverage for State Contract Physicians (Commentary) 440-6

Medical Crusade Moss Has Evidence But Little Help (Commentary) 926-11
Medical Director Role in Skilled Nursing Facility (Commentary) 439-6
Medical News Around the State 146-2 232-3, 307-4, 375-5, 448-6, 577-7, 670-8, 728-9, 796-10, 930-11, 1,020-12
Meetings 97-1 164-2, 187-3, 312-4, 584-5, 452-6, 575-7, 671-8, 731-9 808-10, 940-11, 1,026-12

On the Insanity Defense (Editorial) 436-6

Organization:
AMA President Delivers Frist Jere Annis Lecture 396-5
Annual Meeting Scientific Program Approved for AMA Category 1 Credit 1,007-12
A Review of Florida's Comprehensive Medical Liability Law - 1976 652-8
Burns A. Dobbins Honored by Broward Colleagues 370-5
Component County Medical Societies of Florida 588-7
Conference on Identification of Needs and Standards for In-Hospital Critical Care 658-8, 1,010-2
Dr. Astler's Year As Our President 367-5
Florida's Dr. Francis T. Holland, Elected AMA Vice President 657-8
FMA Announces New Florida Physician's Insurance Reciprocal 1,004-12
FMA Officers, Councils and Committees 585-7
FMA PLI-Trust PIMCO Announce New Risk Management Program for Florida Hospitals 1,012-12
102nd FMA Annual Meeting Preliminary Program 147-2
100th FMA President, Jack A. MaCris 433-6
FMA Special Meetings, September 1976 722-9
FMA House of Delegates to Convene in Orlando 86-1
Florida Supreme Court Considers Contingency Fee Modification 87-1
Journal Wins Major Award 917-11
1977 Professional Liability Insurance Premiums 1,005-12
Position Regarding Medical Professional Liability 84-1
Preliminary Program—103rd FMA Annual Meeting 918-11
Report on National Rural Health Conference 787-10
Special Thanks to Our Contributors 157-2
Summary of Actions, FMA Board of Governors 228-3, 548-7, 914a-11
Telephone Directory, Specialty Headings for Members of FMA 659-8
Thanks to Contributors to Special Dermatology Issue 157-2
They Will Be There 297-4
Two FMA Members Honored 724-9
Volusia County Physician Ministers to Speedway Injured 788-10

Others Are Saying:
American Medicine in 1776 Was Simple and Primitive 302-4
A Visit to the Doctor or What's it Like to Be a Patient? 381-5
Determining the Right To Die, A Physician's Responsibility 243-3
If You Become A Computer Kickout 569-7
Man, the Vanishing Species 301-4
Medicaid Should Work Better 806-10
Middle Class—A Sensible Society 915-11
National Health Service 245-3
Parapsychology and Medicine 114-2
Patient Recall 915-11
Politics is Making Bad Medicine 382-5
Rising Militancy 20-1
That's a Fact 1,023-12
The Art of Delivering Bad News 807-10

The Medical Commons 300-4
The Physician and His Manners 383-5
The Waiting Game 451-6
Time Is Valuable! 92-1
Undergraduates: Your Responsibility 651-8
Very Real Peer Review 245-3

PLI Up-Date (Commentary) 298-4

President's Page:
(President's page with no title) 597-8
A Stronger Role 465-7
Critique on Today's Scenes: Part I 109-2
Doctors as Fiscal Agents 257-4
Let Freedom Ring 397-6
Merry Christmas and A Happy New Year 953-12
My Thanks to All 325-5
Open Letter To America 7-1
P-R 745-10
Thanksgiving 823-11
We Can Do the Job 117-3
Will It Float? 685-9

Rebuttal to Mr. Kilpatrick 927-11

Reflections (Editorial) 361-5

Rhabdomyosarcoma of Head and Neck in Children (Scientific) 980-12

Special Articles:
A Look At the "Baker Act" 287-4
Commencement Address - 1976 781-10
Commencement Address 995-12
Community Mental Health Centers Or Is There A Better Way? 353-5
Contingency Fees 427-6
Drug Substitution Law 714-9
Epidemic Transient Situational Disturbance In an Elementary School 357-5
FMA Convention 1976, A Student Delegates Report 648-8
Hospital Contingency Plan for "Swine -Flu" Epidemic 784-10
Multimillion Dollar Adjustment of Workmen's Compensation Fees 425-6
National Health Insurance 135-2
Notes on Russian Psychiatry 715-9
Pensacola Musical Medics Find Harmonious Way to Serve 647-8
Physicians' Rights to Hospital Privileges 553-7
Sunshine Station - Florida's First Camp for Children with Asthma 710-9
The Chaning Image of Medical Education in Brazil 718-9
The Educated Heart 707-9
The National Health Planning and Research Development Act (PL 93-641) 429-6
The Real World for Doctors 558-7

Special Issue - Dermatology
Introduction by Special Guest Editor 23-1
An Approach to Perplexing Dermatologic Disorders 24-1
The Dermatologist 27-1
New Look at Gene Determinants and Their Controls 29-1
The Kerating in Dermatologic Diagnosis 32-1
Malignant Lymphomas, Mycosis Fungoides and Allied Diseases 35-1
The Tender, Red Nodules of the Skin Syndrome 37-1
Fluorescent Antibody Patterns in Bullous Dermatoses and Lupus Erythematosus 42-1
Skin Problems of Infants 45-1
The Rational Approach to Acne Vulgaris 48-1
Alopecia 51-1
Successful Hair Transplant Surgery, A Composite Evaluation 55-1
Let There Be Light 57-1
Pigmentary Changes in Skin Diseases 60-1
Problems in Pigmentation 62-1
Malignant Melanoma or Harmless Mole? 65-1
Cancer of the Skin 67-1
Surgical Repair of Operative Defects After Skin Cancer Excision 71-1
Current Status of Syphilis and Other Venereal Diseases 74-1
Herpes Progenitalis and Condyloma Acuminata 78-1
Mighty Mites and Other Bug Bites 81-1

Special Issue - Snakebite Symposium:
Poisonous Snakebite: A Review, 1. The Snakes and Their Venom 191-3
Poisonous Snakebite: A Review, 2. Symptomatology and Treatment 201-3

Special Issue - Medical History
Doctors and Disease in the British Floridas ... 611-8
Edward Jelks, M.D., A Biography of Achievement 622-8
Notes On the History of Leprosy to 1921 631-8
The Romantic Necrophiliac of Key West 642-8

Special Issue - University of Miami School of Medicine
Resolution 755-10
An Historical Perspective of the University of Miami School of Medicine 756-10
A Medical Center and the Achievements of A Young Medical School 758-10
Medical Students 764-10
The Research Program of the University of Miami School of Medicine 767-10
The University of Miami School of Medicine's Alumni During the School's First Twenty Years 771-10

Special Issue - Neurological Surgery
Introductions 835-11
Pioneering in Neurological Surgery in Florida . 837-11
Recent Advances in Diagnosis and Treatment of Primary Intracranial Tumors 840-11
Transsphenoidal Hypophysectomy in Metastatic Breast Cancer 844-11
Cerebral Aneurysm 847-11
Microsurgical Treatment of Neurovascular Disease 850-11
Surgical Therapy of Epilepsy 855-11
Head Injuries in a Community Hospital-Day-to-Day Management 860-11
Normal Pressure Hydrocephalus—A Treatable Cause of Dementia 863-11
Intracranial Pressure Monitoring in Clinical Practice 865-11
Cranioplasty: Use of a Combination Graft 869-11

Cervical Disc Disease and Other Causes of Upper Extremity Pain 872-11
Cervical Spondylosis 876-11
Traumatic Unilateral Facet Locking in the Cervical Spine 880-11
Bony Encroachment of the Lumbar Spine, A Cause of Low Back Surgery Failure 884-11
Chronic Spinal Radiculopathy with Particular Reference to Spinal Arachnoiditis, A Surgical Viewpoint 889-11
Neurosurgical Care of the Patient With Spina Bifida Aperta 892-11
A Synopsis of the Neurosurgical Treatment of Pain 895-11
Selective Percutaneous Radiofrequency Coagulation of Gasserian Ganglion for Trigeminal Neuralgia 898-11
Stereotactic Percutaneous Cordotomy 900-11
Electrical Modulation of Nervous System Function 902-11
Peripheral Nerve Stimulation for Pain Control 903-11
Electrical Stimulation of the Spinal Cord in Patients With Demyelinating and Degenerative Diseases of the Central Nervous System 906-11
Cerebeller Stimulation for Cerebral Palsy 910-11

Statement of Ownership 314-4, 942-11

The Dizzy Patient ENG, Yes or No? (Scientific) .. 418-6
The Fifth Pathway (Editorial) 141-2
The Physician Legislator (Editorial) 293-4
The National Health Crisis in Britain 954-12
The Red Tide and Other Phytoplanktonic Thoughts (Scientific) 409-6
The Spectre at the Feast (Editorial) 1,001-12
Treadmill Exercise Testing (Scientific) 984-12
Tuberculosis, A New Era (Scientific) 278-4
Tuberculosis, and the Community Hospital, A Synopsis (Scientific) 282-4
Urticaria, Papular (Scientific) 992-12

Woman's Auxiliary:
American Medical Association Education and Research Foundation 310-4
Auxiliary President's Report for the Year 1975-76 578-7
European Medical Seminar 295-4
Tenth Annual Benefit Art Show 246-3, 308-4
Woman's Auxiliary to FMA 309-4

AUTHORS

Abel, Marshall, North Miami Beach 291-4
Abramson, Neil, Jacksonville 210-3
Acosta-Rua, Gaston J., Jacksonville 847-11
Agliano, Dennis, Tampa 418-6
Alper, Louis, Miami 303-4
Andrews, Carl E., West Palm Beach 210-3
Aranda, Juan M., Miami 695-9
Astler, Diane, Boynton Beach 109-2, 479-7
Astler, Vernon B., Boynton Beach 7-1
84-1, 135-2, 177-3, 257-4, 325-5, 479-7, 656-8, 662-8
Atchison, Gerald S., Miami 767-10
Auld, A. W., West Palm Beach 889-11
Ayoub, Elia M., Jacksonville 344-5

Baker, Carlton, Tampa 210-3
Baker, R. Johnson, Gainesville 65-1
Barry, Peg, Arlington, Texas 239-3
Bartruff, J. Kent, Sarasota 81-1
Baumal, Allen, Miami Beach 35-1
Bauer, Robert E., Miami Beach 569-7
Befeler, Benjamin, Miami 695-9
Behnke, Roy H., Tampa 300-4
Beller, Harry E., Miami 160-2
Bloom, Frederick L., Gainesville 710-9
Boggs, John S., Jacksonville 898-11
Brackett, Thomas O., Winter Haven 835-11
Bridgeford, Paul H., St. Petersburg 344-5
Brill, Thomas M., Gainesville 805-10
Brodin, Michael B., Clearwater 24-1
Brown, Thomas, Morona-Santiago, Ecuador 726-9
Bucher, Robert, Jacksonville 421-6
Bucy, Paul C., Tryon, N.Y. 835-11
Burford, Fred J., Fort Myers 805-10
Burton, Charles, Minneapolis, Minnesota 902-11

Carter, Vernon H., Boca Raton 32-1
Cassel, Chester, Miami 417-6
Castellanos, Agustin Jr., Miami 695-9
Cerda, James J., Gainesville 718-9
Chandler, Howard C., Jacksonville 847-11
Chappell, Frank, Chicago, Illinois 302-4
Childers, Richard C., Gainesville 78-1
Christie, John P., Miami 414-6
Cleveland, John Q. Jr., Miami 282-4
Coggins, Deborah, Gainesville 277-4
Cohan, Robert H., Pensacola 992-12
Cohen, Bernard H., Miami 55-1
Collins, Clyde M., Jacksonville 161-2
Conner, Collins, Tallahassee 806-10
Contarini, Osvaldo, Jacksonville 349-5
Cox, Herbert A., Tampa 418-6
Cronin, Terrence A., Indialantic 71-1
Crumbley, James J., Tampa 383-5
Cullen, Robert F., Miami Beach 910-11
Curtis, Lindsey R., Salt Lake City, Utah 92-1
Cusani, Benedict A., Miami 702-9

Davis, Courtland H. Jr., Winston-Salem, N.C. 835-11
Davis, Frank M., Tallahassee 872-11
Davis, Ross, Miami Beach 910-11
Day, Arthur L., Gainesville 840-11
Dever, Richard C., Jacksonville 88-1
Doff, Simon, Jacksonville 421-6
Donelan, Richard T., Jacksonville 451-6
Dodd, Larry A., Jacksonville 372-5
Dodge, R. Edward, Inverness 787-10
Dooley, Donald M., Miami 906-11
Douglass, William P., Daytona Beach 784-10
Drucker, Paul, Edison, New York 805-10
Duenas, Danilo, Miami Beach 910-11
Dugan, Charles C., West Palm Beach 23-1, 29-1

Eaglstein, William H., Miami 62-1
Engel, Howard, Miami Beach 910-11
Epstein, Samuel, Palm Beach 376-5
Eschenburg, Charles G., Delray Beach 469-7

Fanizzi, William, Fort Lauderdale 971-12
Fass, Paul, Miami 291-4
Fischer, Roswitha B., Pensacola 287-4, 353-5
Fogel, Bernard J., Miami 142-2, 606-8, 758-10, 771-10
Foraker, Alvan G., Quincy, Massachusetts 642-8
Francischetti, Emilio A., Sao Paulo, Brazil 718-9
Frankel, N. Ralph, North Miami 284-4
Frazier, Claude A, Asheville, North Carolina 805-10
Funt, Tobias R., Fort Lauderdale 27-1

Garcia-Bengochea, Francisco, Gainesville 840-11
Geissinger, James D., Tallahassee 872-11
Gennaro, Joseph F. Jr., New York 210-3
Goff, R. Daley, Jacksonville 349-5
Goldberg, Harry C., Palm Beach 234-3, 572-7
Goldman, Gerald C., St. Petersburg 37-1
Gonzalez, Arturo G., Tampa 436-6
Gosch, Hank H., Clearwater 863-11
Gottlieb, Norman L., Miami 339-5
Gray, Robert G., Miami 339-5
Greene, Richard S., Plantation 57-1
Green, Jacob, Jacksonville 572-7

Habal, Mutaz B., Gainesville 345-5, 869-11, 980-12
Hansen, Gorm P., Fort Lauderdale 245-3
Harrington, William J., Miami 767-10
Hayes, Charles P., Jacksonville 569-7
Heard, Milton G., Boca Raton 42-1
Heffner, George P., Fort Lauderdale 805-10
Hellman, Daniel S., St. Petersburg 356-5
Henderson, Mrs. C. Brooks, Ocala 578-7
Herskowitz, Allan, Miami Beach 291-4
Hibbs, Samuel G., Tampa 356-5
Hicks, John H., Coral Gables 60-1
Hodes, Richard S., Tampa 558-7
Hogshead, Howard P., Jacksonville 807-10
Horn, Kenneth A., Jacksonville 372-5
Howery, Stephen E., Winter Park 158-2
Huntley, Henry C., Jacksonville 210-3

Ioannides, George, Miami Beach 51-1

Kahn, Guinter, North Miami Beach 45-1
Kallan, Joel P., Miami 158-2
Kalser, Martin H., Miami 666-8
Kasprak, Mary, Miami 906-11
Kilpatrick, James, Woodville, Va. 926-11
Kramer, Karl J., Miami 62-1
Kramer, Paul W., Fort Lauderdale 895-11
Kruse, John C., Jacksonville 10-1
120-2, 180-3, 260-4, 332-5, 403-6, 472-7

Leake, Donald, Gainesville 869-11
Lehman, David J., Hollywood 160-2, 427-6, 446-6
Lesser, Milton E., Miami Beach 569-7
Lewis, Leonard A., Miami 55-1
Lipman, Joel K., Gainesville 648-8
Llinas, Jose J., Gainesville 271-4
London, Rose E., Miami Beach 569-7
Lupo, Joseph F., Tampa 243-3
Lyerly, James G. Sr., Jacksonville 837-11, 847-11
Lyerly, James G. Jr., Jacksonville 847-11

MacDonald, Jack W., Tallahassee 277-4
MaCris, Jack A., St. Petersburg 397-6
465-7, 597-8, 685-9, 714-9, 745-10, 823-11, 953-12, 954-12
Mandy, Stephen H., Miami 48-1
Maniscalco, Jack E., Gainesville 345-5, 869-11
Matthews, Joseph G., Orlando 344-5
McCallum, J. E., Pittsburgh, Pennsylvania 180-3
McEuen, Marianne B., Jacksonville 281-4
McMichael, Julia E., Gainesville 710-9
McSwain, George H., Daytona Beach 141-2
Meier, Gerald, Fort Lauderdale 895-11
Mendelson, Marilyn, Miami 771-10
Menn, Henry, Miami 67-1
Messer, A. Lee, St. Petersburg 277-4, 792-10
Miller, Alan B., Jacksonville 421-6
Modell, Jerome H., Gainesville 123-2
Moore, H. K., Key West 301-4
Morrison, Glenn, Coral Gables 844-11
Moseley, Linda C., Jacksonville 622-8
Mount, Lester A., New York, New York 835-11
Mozingo, J. Robert, Gainesville 876-11
Murray, David, Jacksonville 421-6
Myerburg, Robert, Miami 695-9

Nitzkin, Joel L., Miami 282-4, 357-5
Norrell, Horace, Sarasota 880-11
Nunn, Daniel B., Jacksonville 238-3, 381-5

Ogden, Al, Tallahassee 663-8
Orebaugh, John E., St. Petersburg 433-6

Page, Larry K., Miami 892-11
Palmer, Roger, Miami 210-3
Papper, E. M., Miami 116-2
336-5, 606-8, 748-10, 458-10, 771-10, 781-10
Parham, W. Harold, Jacksonville 652-8, 1,004-12
Pedrero, Edward Jr., Tampa 114-2, 445-6
Perez, Luis M., Sanford 429-6
Phillips, Philip B. Pensacola ... 278-4, 353-5, 437-6, 715-9
Picaza, Jorge A., Miami 903-11
Pickering, Michael J., Tampa 975-12
Podoll, Elliott, Miami 651-8
Popejoy, Michael W., Orlando 234-3, 666-8
Prather, E. Charlton, Tallahassee 372-5, 565-7
440-6, 991-12

Quillian, Warren W. II, Coral Gables 129-2
Resnik, Sorrel S., Miami 55-1
Rhoton,Albert L. Jr., Gainesville 835-11, 850-11
Richards, James F. Jr, Orlando 425-6
Richmond, Joy S., Gaithersburg, Maryland 631-8
Robertson, Pat, Daytona Beach 784-10
Robinson, John K., Miami 771-10
Rooks, John J. Jr., Gainesville 980-12
Roque, Juan L., Jacksonville 421-6
Rosomoff, Hubert L., Miami 884-11
Ross, Milton S., Miami 74-1
Rydell, Ralph E., Tampa 900-11

Sales, Louis M., Jacksonville 344-5
Schadel, Lees M. Jr, Fort Lauderdale 915-11
Schiebler, Gerold L.,Gainesville 293-4
298-4, 361-5, 602-8, 692-9, 752-10, 830-11, 964-12
Schreiber, Herman, Pensacola 376-5
Scott, Thomas E. Jr., Daytona Beach 860-11
Shulman, Stanford T., Gainesville 564-7
Slaughter, Frank G., Jacksonville 139-2, 1,001-12
Smith, Donn L., Tampa 19-1, 264-4, 468-7, 826-11
Smith, Fred O., Dunedin 379-5
Sorensen, Bruce F., Salt Lake City, Utah 835-11

Spangler, Dennis L., Gainesville 710-9
Spellacy, William N., Gainesville 442-6
Sperber, Perry A., Daytona Beach 159-2
Stanford, Henry King, Coral Gables 756-10
Steinbook, Richard M., Miami 445-6
Stephan, Ralph M., Tampa 245-3
Stetson, Chandler A., Gainesville 184-3, 406-6, 689-9, 958-12
Steward, W. Dean, Marianna 304-4
Stewart, Franz H. Jr., Miami (Scientific) 984-12
Stibitz, Marie, Miami 906-11
St. Mary, Edward W., Miami 20-1, 382-5, 1,023-12
Straight, William M., Miami 234-3, 611-8
Sullivan, Edward J. Jr., Jacksonville 847-11
Sypert, George W., Gainesville 855-11

Talbott, John H., Miami 702-9
Taslimi, Kamal, Fort Lauderdale 971-12
Tate, Charles F., Miami 569-7
Thrasher, John E., Jacksonville 303-4, 652-8
Tolmach, Robert S., Miami Shores 835-11
Trask, Arthur, Boynton Beach 658-8
Tweed, Gilbert, Daytona Beach 860-11

Upson, Phyllis, Gainesville 710-9

Van Eldik, D. L., Lake Worth 367-5
Van Mierop, L. H. S., Gainesville 191-3, 201-3
Vickers, F. Norman, Pensacola ...304-4,647-8, 732-9, 915-11
Vasquez, Anthony, Fort Lauderdale 971-12
Vries, John K., Gainesville 685-11
Vroom, Fred Q., Tallahassee 238-3

Walker, James W., Jacksonville 1,005-12, 1,012-12
Weech, A. Ashley, Gainesville 409-6, 995-12
Weiffenbach, Don D., Lake City 1,002-12
Welch, F. Todd, Miami 892-11
Whang, C. Jin, Gainesville 876-11
Wilentz, Joel, M., Plantation 57-1
Williams, J. B., Jacksonville 667-8
Wilson, Warren D., Gainesville 876-11
Wittig, Heinz J., Gainesville 710-9
Wollin, Joan L., Leesburg 553-7

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Florida Organizations of Medical Interest
Meetings and Officers

Organization	President	Secretary	Annual Meeting
Florida Medical Association	Jack A. MaCris, St. Petersburg	Robert E. Windom, Sarasota	Bal Harbour, May 4-8, 1977
Florida Specialty Societies			
Allergy Society	Gerald F. Carter, Miami	Rodger J. Zwemer, Vero Beach	
Anesthesiologists, Society of	George T. Edwards, Ft. Lauderdale	John K. Petrakis, Tampa	
Chest Phys., Fla. Chap., Am. Col.	Wilber G. Avery, Miami	Roberto Llamas, Miami Beach	
Dermatology, Society of	Wilfred D. Little, Tampa	Daniel Roberts, Rockledge	
Emergency Phys., Fla. Chap., Am. Col.	Howard J. Leitman, Miami	Alan Maurer, Miami	
Endocrine Society	Eugene T. Davidson, Lakeland	George Heffner, Ft. Lauderdale	
Family Physicians, Academy of	T. Byron Thames, Orlando	Charles A. Dunn III, Miami	
Gastroenterologic Society	William G. Baker Jr., St. Pete	Walter E. Morris Jr., Jacksonville	
Internal Medicine, Society of	Martin E. Liebling, Miami	Arthur L. Naddell, Ft. Lauderdale	
Neonatal-Perinatologists, Society of	Charles R. Bauer, Miami	Edward R. Westmark, Pensacola	
Nephrology, Society of	R. Wayne Miller, Pensacola	William W. Anderson, Miami	
Neurology, Society of	Jacob Green, Jacksonville	William M. Haycook, Jacksonville	
Neurosurgical Society	Thomas O. Brackett, Winter Haven	Frank M. Davis, Tallahassee	
Nuclear Physicians, Association of	Lawrence R. Muroff, Tampa	Dorothy T. G. Lloyd, Orlando	
Obstetric and Gynecologic Society	William H. Kirkley, Ft. Lauderdale	George N. Lewis, Tallahassee	
Ophthalmology, Society of	Alfred G. Smith II, Miami	Reginald J. Stambaugh, West Palm Beach	
Orthopedic Society	Walter C. Jones III, Coral Gables	Howard P. Hogshead, Jacksonville	
Otolaryngology, Society of	Richard A. Bagby, Tampa	Hueston C. King, Miami	
Pathologists, Society of	K. Kendall Pierson, Gainesville	Daniel Seckinger, Miami	
Pediatric Cardiologists, Association of	Henry Gelband, Miami	Robert H. Miller, Jacksonville	
Pediatric Surgeons, Association of	James L. Talbert, Gainesville	Ralph L. Swank II, Tampa	
Pediatric Society, Fla. Chap., Am. Academy of Pediatrics	W. Reed Bell, Pensacola	Michael Steiner, North Palm Bch.	
Physical Medicine & Rehabilitation, Soc. of	David L. Lipkin, N. Miami Bch.	Hector A. Freytes, Miami	
Physicians, American College of	Charles K. Donegan, St. Pete	None	
Plastic & Reconstructive Surgery, Soc. of	Bernard L. Kaye, Jacksonville	William F. Hogan, Ft. Lauderdale	
Preventive Medicine, Society for	James T. Howell, Palm Springs	John F.McGarry, Jacksonville	
Psychiatric Association, Dist. Branches	Daniel S. Hellman, St. Petersburg	Richard E. Gordon, Gainesville	
Radiological Society	Paul J. Popovich, Melbourne	John T. Johnson, Sanford	
Rheumatology, Society of	Jacques Caldwell, Gainesville	Louis R. Ricca, St. Petersburg	
Surgeons, Fla. Chap., Am. College of	Martin G. Gould, Fort Pierce	Frank A. Mergen Jr., Miami	
Surgeons, Soc. of Colon and Rectal	Manuel Carbonell, Miami	Walter W. Hamilton, St. Pete	
Surgeons, Association of General	F. Joseph Burns, St. Petersburg	Robert H. Hux, Leesburg	
Surgeons, Internat'l. Col. of, Fla. State Div.	Julian A. Rickles, Miami Beach	None	
Thoracic Surgeons, Society of	Daniel B. Nunn, Jacksonville	Penny Lanson, Miami	
Urological Society	R. Benjamin Moore, W. Palm Beach	Alvie C. McCully, Tallahassee	
FLORIDA DIVISION:			
American Cancer Society, Fla. Div.	Joseph K. Isley Jr., Ft. Myers	Mrs. Charles Prescott, Tallahassee	Miami Beach, Nov. 4-6, 1977
Arthritis Foundation, Fla. Chap.	Samuel P. Lewis, Hollywood	Theodore K. Grahn, Holmes Bch.	Tampa, May 1977
Blue Shield of Florida, Inc.	J. W. Herbert, Jacksonville	John S. Slye, Jacksonville	Bal Harbour, May 4-8, 1977
Board of Medical Examiners	Victor J. Martinez, Tampa	Leo Grossman, Miami	Tampa, January 23-25, 1977
Epilepsy Foundation	Mark Buchbinder, Miami	Clara Warledge, Miami	Tampa, October 1977
Heart Association	Jack J. Greenberg, Miami Beach	S. Lee Crouch, Hallandale	St. Petersburg Bch., May 22, '7
Kidney Foundation, Fla. Co-ord. Coun.	(Not available)		
Leukemia Society of America, Fla. Div.	Irving J. Whitman, Miami	Robert H. Newman, Miami	Miami, June 1977
Lung Association	Jeanne Malchon, St. Petersburg	Howard DuBose, Lakeland	Tampa, Nov. 20, 1977
Mental Health Association of Florida	James A. Sprigg, Orlando	Elva Rath, Lakeland	Tallahassee, Oct. 6-8, 1977
Multiple Sclerosis Society, National	(Not available)		
Muscular Dystrophy Assn., Fla. Dist.	(Not available)		
Prevention of Blindness, Society for	Robert W. Andrew, Tampa	Arthur G. Garrison, Tampa	Tampa, Feb. 4-5, 1977
Retarded Children, Fla. Assn. for	William J. Taylor, Tequesta	Richard C. Brannen, Fort Myers	Jacksonville, September 1977

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

Classified Ads

physicians wanted

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MIAMI, FLORIDA: G.P. — Seven man multispecialty, fee-for-service group is seeking a G.P. to join the group. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida 33013. Phone (305) 696-0842.

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INTERNIST—SUBSPECIALTY ALLERGY, board certified in both, Florida license, American graduate, ten years practice experience, desires group or solo practice. Write C-767, P.O. Box 2411, Jacksonville, Florida 32203.

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THERAPEUTIC RADIOLOGIST, Board eligible. Florida license, seeking position. Write 41 Tara Drive, Roslyn, N.Y. 11576 or phone (516) 626-3650.

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